the Journal
MICHIGAN
STATE MEDICAL SOCIETY
MARCH 1960 • VOLUME 59 • NUMBER 3



Dedicated to the Memory of
L. Fernald Foster, M.D.,
Long-time Secretary, M.S.M.S.

allergen on rye

when that delectable snack boomerangs

BENADRYL®

antihistaminic-antispasmodic

gives prompt, comprehensive relief

In food sensitivity, BENADRYL provides simultaneous, dual control of allergic symptoms. Gastrointestinal spasm, plus the cutaneous and respiratory symptoms associated with food allergy are favorably affected by the *antihistaminic action* of BENADRYL. Concurrently, its *antispasmodic effect* alleviates colicky pain, nausea and vomiting. This duality of action makes BENADRYL equally valuable throughout the entire spectrum of allergic disorders.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms including: Kapseals,® 50 mg. each; Kapseals, 50 mg., with ephedrine sulfate, 25 mg.; Capsules, 25 mg. each; Elixir, 10 mg. per 4 cc.; and for delayed action, Emplets,® 50 mg. each. For parenteral therapy, BENADRYL Hydrochloride Steri-Vials,® 10 mg. per cc.; and Ampoules, 50 mg. per cc.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

10149



NOW many more hypertensive patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

Except for one case of mild blood-pressure elevation (150/90) **no hypertension was seen in any of 1500 patients**† as a result of treatment with DECADRON—the new and, on a milligram basis, most potent of all corticosteroids. **Hypertension induced by other steroids diminished or disappeared.**

Thus with DECADRON, hypertension no longer appears to be a contraindication to successful corticosteroid therapy. And the dramatic therapeutic impact of DECADRON was virtually unmarred by diabetogenic or psychic reactions . . . Cushingoid effects were fewer and milder . . . and there were no new or "peculiar" side effects. Moreover, DECADRON helped restore a "natural" sense of well-being.

†Analysis of clinical reports.

Decadron* DEXAMETHASONE

treats more patients more effectively

*DECADRON is a trademark of Merck & Co., Inc. ©1959 Merck & Co., Inc.

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., Inc., PHILADELPHIA 1, PA.

Say you saw it in the Journal of the Michigan State Medical Society

the Journal MICHIGAN
STATE MEDICAL SOCIETY

Volume 59 Number 3

March, 1960

PUBLICATION COMMITTEE
BRADLEY M. HARRIS, M.D.....Ypsilanti
Chairman
WM. BROMME, M.D.....Detroit
C. N. HOYT, M.D.....Port Huron
E. S. OLDHAM, M.D.....Breckenridge
O. J. JOHNSON, M.D.....Bay City

Office of Publication
2642 University Avenue
Saint Paul 14, Minnesota

Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Assistant Editor
L. J. BAILEY, M.D.
Medical Concourse, Northland Center
Detroit 35, Michigan

Secretary and Business Manager of THE JOURNAL
D. BRUCE WILEY, M.D.
45310 Van Dyke, Utica, Michigan

Executive Director
WM. J. BURNS, LL.B.
606 Townsend Street, Lansing 15, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone IVanhoe 2-1158.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, $6.00; single copies, 60 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

© 1960 by Michigan State Medical Society

PRINTED IN U.S.A.



THE COVER

L. Fernald Foster, M.D., eminent pediatrician of Bay City, served brilliantly and tirelessly as Secretary of the Michigan State Medical Society from September 1936 until his death in May 1959. Medicine was both his vocation and his avocation.

IN THIS ISSUE

STATE SOCIETY SECTION 377
President's Page—Legacy ... 376
Challenge of Today ... 377
Annual Session of the Council, January 29-30, 1960 ... 460

PUBLIC RELATIONS 395
Challenges Doctors to Meet Public's Need, and to Sell ... 395

SOCIO ECONOMICS 403
M.D. Gets Smaller Share of Medical Care Dollar ... 403
Care for Aged Challenge Met by Blue Shield Plans ... 403
Urges Social Security Study ... 404
Sees '60 Big for Michigan ... 404

CLINICAL 417
Antibiotics—Their Use and Abuse—*Perrin H. Long, M.D., F.R.C.P.* ... 417
Seminar on Graduate Medical Education:
Welcome—*Milton R. Weed, M.D.* ... 419
Introduction—*H. C. Saltzstein, M.D.* ... 419
The Internship—*John C. Nunemaker, M.D.* ... 420
The Role of a Director of Medical Education—*John C. Leonard, M.D.* ... 423
Panel Discussion—*Harry A. Towsley, M.D.*, Moderator ... 425
Hidden Occupational Hazards in Industry—*Henry J. Kreulen, M.D.* ... 430
Current Use of New Drugs in Anesthesiology and in the Treatment of Pain—*John S. Lundy, M.D.* ... 436
Eye Wounds—*M. D. Bentley, M.D.* ... 439
Oral Cholecystography—*Philip W. Dorsey, M.D.* and *John L. Anderson, M.D.* ... 442
Professional Liability Insurance—*C. E. Umphrey, M.D.* ... 446
California Malpractice—*George H. Cary, LL.B.* ... 448

EDITORIAL 451
L. Fernald Foster, M.D. ... 451
Adequate Patient Hospital Care ... 452
"The Patient Gets a Break" ... 452
Hospital Utilization ... 453
Michigan Chiropody Association Takes Issue ... 454
Council Elections ... 454

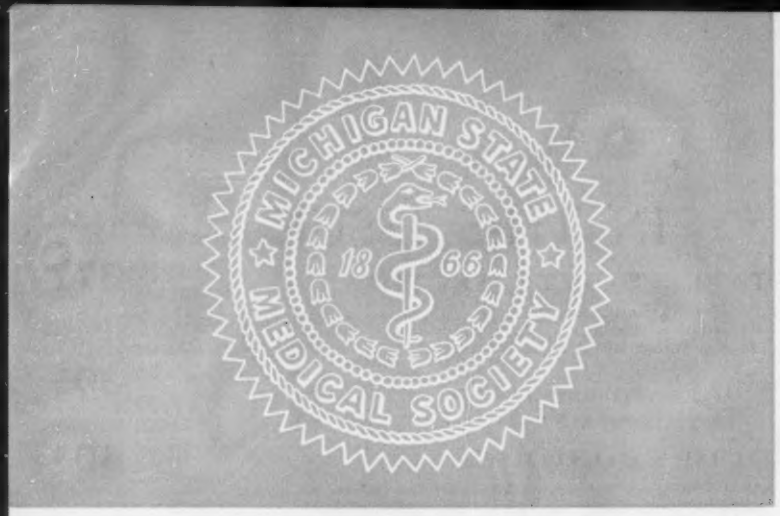
DEDICATION 455
"Fern Was a Doctor's Doctor, Parent's Doctor, Patient's Doctor" ... 455

NATIONAL AND WORLD 475
Make Study of Discipline in Medical Profession ... 475
AMA Report Describes Washington Situation on Forand Legislation ... 476
Germany Host to WMA ... 476

ANCILLARY 483
Says Poor Reporting Could Lead to Medical Care Lag ... 483
Hold MAP Congress ... 484
Reveal Speakers for May 4 "Symposium on Cerebral Palsy" ... 486

NEWS BRIEFS 495

MISCELLANEOUS
Heart Beats ... 490
C. A. Conshus, M.D., Says ... 494
In Memoriam ... 508
Communications ... 511
Michigan Authors ... 512
Editorial Comment ... 514



OFFICERS OF THE SOCIETY

1959-1960

President	MILTON A. DARLING, M.D.	Detroit
President-Elect	K. H. JOHNSON, M.D.	Lansing
Secretary	D. BRUCE WILEY, M.D.	Utica
Treasurer	W. A. HYLAND, M.D.	Grand Rapids
Speaker	J. J. LIGHTBODY, M.D.	Detroit
Vice Speaker	H. F. FALLS, M.D.	Ann Arbor

THE COUNCIL

H. J. MEIER, M.D., *Chairman*, Coldwater
T. P. WICKLIFFE, M.D., *Vice Chairman*, Calumet
D. BRUCE WILEY, M.D., *Secretary*, Utica

	District		*Term Expires*
A. E. SCHILLER, M.D.	1st	Detroit	1961
O. B. McGILLICUDDY, M.D.	2nd	Lansing	1960
H. J. MEIER, M.D.	3rd	Coldwater	1960
WM. A. SCOTT, M.D.	4th	Kalamazoo	1961
C. ALLEN PAYNE, M.D.	5th	Grand Rapids	1961
H. H. HISCOCK, M.D.	6th	Flint	1961
C. N. HOYT, M.D.	7th	Port Huron	1962
E. S. OLDHAM, M.D.	8th	Breckenridge	1962
D. G. PIKE, M.D.	9th	Traverse City	1962
O. J. JOHNSON, M.D.	10th	Bay City	1962
W. M. LeFEVRE, M.D.	11th	Muskegon	1963
B. T. MONTGOMERY, M.D.	12th	Sault Ste. Marie	1963
T. P. WICKLIFFE, M.D.	13th	Calumet	1963
B. M. HARRIS, M.D.	14th	Ypsilanti	1964
R. J. MASON, M.D.	15th	Birmingham	1960
G. THOMAS McKEAN, M.D.	16th	Detroit	1960
W. W. BABCOCK, M.D.	17th	Detroit	1963
WILLIAM BROMME, M.D.	18th	Detroit	1964

MILTON A. DARLING, M.D.	*President*	Detroit
K. H. JOHNSON, M.D.	*President-Elect*	Lansing
J. J. LIGHTBODY, M.D.	*Speaker*	Detroit
H. F. FALLS, M.D.	*Vice Speaker*	Ann Arbor
D. BRUCE WILEY, M.D.	*Secretary*	Utica
W. A. HYLAND, M.D.	*Treasurer*	Grand Rapids
G. B. SALTONSTALL, M.D.	*Past President*	Charlevoix

EXECUTIVE COMMITTEE OF THE COUNCIL

A. E. SCHILLER, M.D.	Chairman
T. P. WICKLIFFE, M.D.	Vice Chairman
W. M. LeFEVRE, M.D.	Chairman, County Societies Committee
B. M. HARRIS, M.D.	Chairman, Publication Committee
O. B. McGILLICUDDY, M.D.	Chairman, Finance Committee
J. J. LIGHTBODY, M.D.	Speaker
H. F. FALLS, M.D.	Vice Speaker
MILTON A. DARLING, M.D.	President
K. H. JOHNSON, M.D.	President-Elect
D. BRUCE WILEY, M.D.	Secretary
W. A. HYLAND, M.D.	Treasurer

SECTION OFFICERS

Dermatology and Syphilology
Alice E. Palmer, M.D. ..... Detroit
Chairman
Jack N. Grekin, M.D. ..... Detroit
Secretary

Gastroenterology and Proctology
Lyle E. Heavner, M.D. ..... Grosse Pointe Farms
Chairman
George T. Bradley, M.D. ..... Detroit
Secretary

General Practice
J. M. McGough, M.D. ..... Detroit
Chairman
Winslow G. Fox, M.D. ..... Ann Arbor
Secretary

Gynecology and Obstetrics
Warren R. Moore, M.D. ..... Detroit
Chairman
Charles M. Bell, M.D. ..... Grand Rapids
Secretary

Medicine
Bert M. Bullington, M.D. ..... Saginaw
Chairman
Hugh W. Henderson, M.D. ..... Detroit
Secretary

Nervous and Mental Diseases
S. M. Gould, Jr., M.D. ..... Ann Arbor
Chairman
R. A. Jaarsma, M.D. ..... Flint
Secretary

Occupational Medicine
William Jend, Jr., M.D. ..... Detroit
Chairman
John H. Ganschow, M.D. ..... Detroit
Secretary

Ophthalmology and Otolaryngology
John E. Magielski, M.D. ..... Ann Arbor
Chairman (Oto.)
Paul L. Cusick, M.D. ..... Detroit
Co-Chairman (Ophth.)
Vital E. Cortopassi, M.D. ..... Saginaw
Secretary (Oto.)
Paul Van Portfliet, M.D. ..... Grand Rapids
Secretary (Ophth.)

Pediatrics
H. T. Knobloch, M.D. ..... Bay City
Chairman
John L. Doyle, M.D. ..... Grand Rapids
Secretary

Public Health and Preventive Medicine
L. V. Burkett, M.D. ..... Flint
Chairman
Vlado A. Getting, M.D. ..... Ann Arbor
Secretary

Radiology, Pathology, Anesthesiology
George C. Frederickson, M.D. ..... Detroit
Chairman (Anesthesiology)
James G. Wolter, M.D. ..... Detroit
Vice Chairman (Pathology)
E. P. Griffin, M.D. ..... Flint
Secretary (Radiology)

Surgery
Robert F. Berry, M.D. ..... Marquette
Chairman
Donald N. Sweeny, Jr., M.D. ..... Detroit
Secretary

Urology
William Bromme, M.D. ..... Detroit
Chairman
Harry E. Lichtwardt, M.D. ..... Birmingham
Secretary

DELEGATES TO A. M. A.

Delegates

	Term Expires
W. D. Barrett, M.D., Detroit	1960
R. L. Novy, M.D., Detroit	1960
G. W. Slagle, M.D., Battle Creek	1960
W. A. Hyland, M.D., Grand Rapids	1961
J. S. DeTar, M.D., Milan	1961
C. I. Owen, M.D., Detroit	1961
O. J. Johnson, M.D., Bay City	1961

Alternates

	Term Expires
L. R. Lender, M.D., Detroit	1960
Wm. Bromme, M.D., Detroit	1960
J. R. Heidenreich, M.D., Daggett*	1960
W. W. Babcock, M.D., Detroit	1961
G. B. Saltonstall, M.D., Charlevoix	1961
J. M. Wellman, M.D., Lansing	1961
B. M. Harris, M.D., Ypsilanti	1961

*To fill unexpired term of R. W. Shook, M.D., deceased.



6-10 HOURS
SUSTAINED THERAPY

ONE *and only ONE*

Timed AMO*dex* CAPSULE

PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

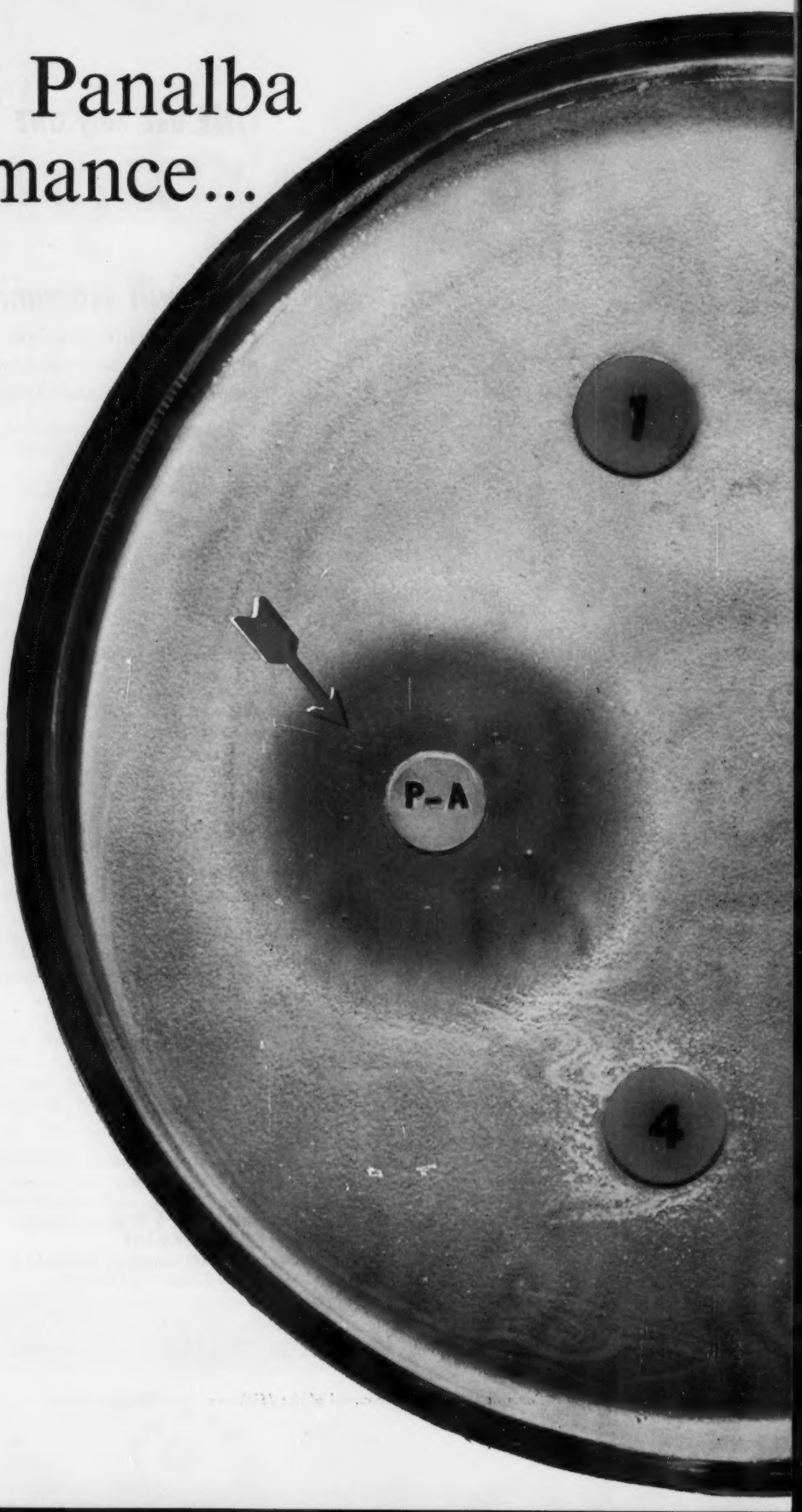
SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 – 2,809,916
2,809,917 – 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan

This is Panalba performance...





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: **new Panalba Half-Strength Capsules in bottles of 16 and 100.**

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.

IN SENILE CONFUSION . . .



CONTINUOUS CEREBRAL OXYGENATION

WITH

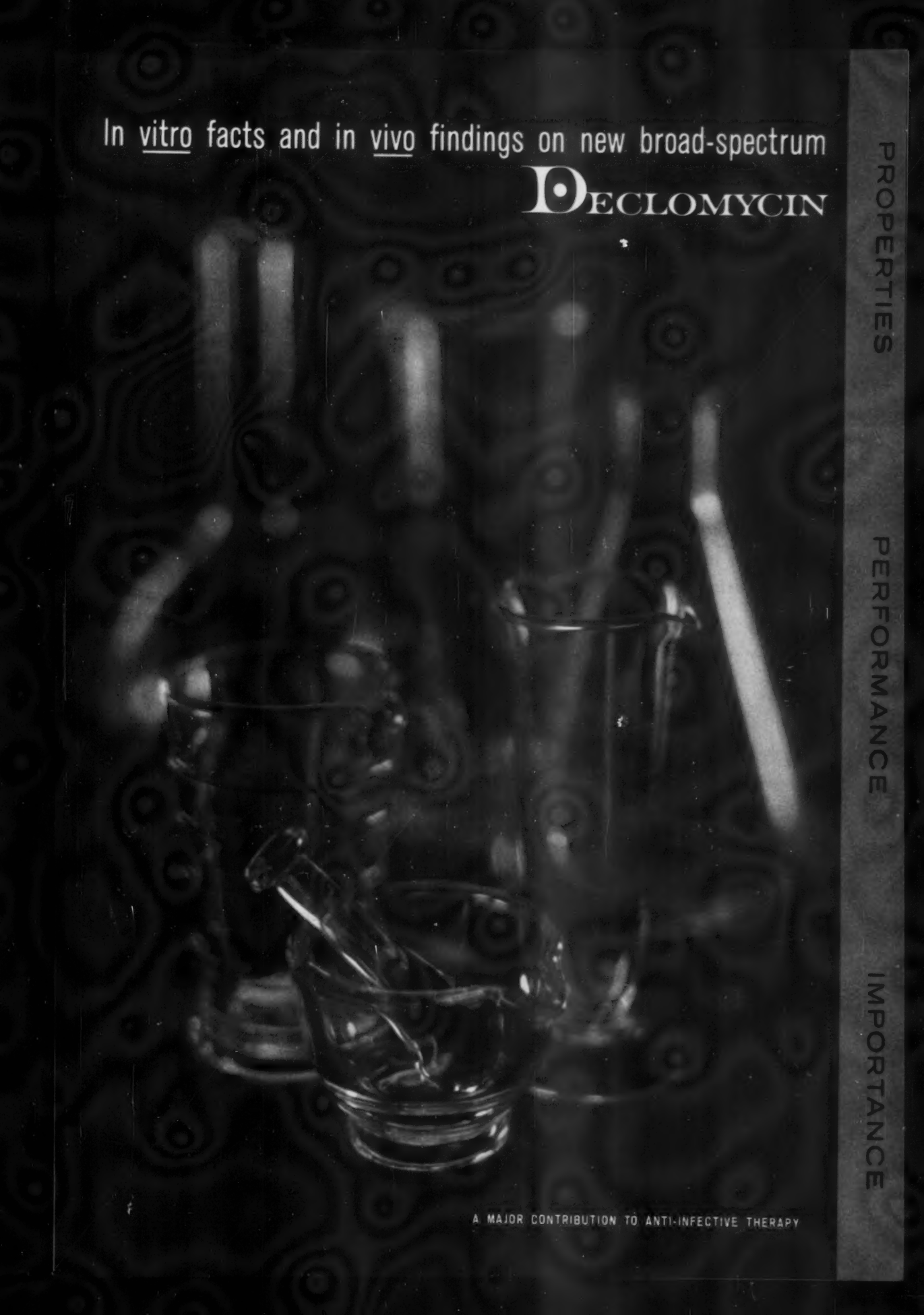
ONE

Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio


In vitro facts and in vivo findings on new broad-spectrum
DECLOMYCIN
PROPERTIES
PERFORMANCE
IMPORTANCE
A MAJOR CONTRIBUTION TO ANTI-INFECTIVE THERAPY

PROPERTIES:

Greater inhibitory action ...lower daily intake than other tetracyclines

A unique new fermentation product of *Streptomyces aureofaciens,* DECLOMYCIN Demethylchlortetracycline achieves notably greater antibiotic activity against infections[2,4,7,8,10,14,19,20,24] because of two basic factors: (1) inherent potency, and (2) greater stability in most body fluids.[15,17,18,27] Actual clinical activity has, in many instances, been better than expected on the basis of *in vitro* sensitivity tests.[14,18,19]

Broad-spectrum control ...with far less antibiotic

Activity levels of DECLOMYCIN Demethylchlortetracycline are higher than those of previous broad-spectrum antibiotics. Hardier strains of various organisms appear to be somewhat more responsive.[4] Apparently some strains of Pseudomonas, Proteus and *A. aerogenes,* frequently refractory to therapy, are sensitive to DECLOMYCIN.[7,23,25,26]

DECLO

PROPERTIES

Sustained peak activity ...greater security of control

Prolonged retention and compatibility of DECLOMYCIN with body fluids provides peak activity between doses.[15,17,18,27] Inhibition of bacteria is more constant.

24-48 hours extra activity...protection against relapse

DECLOMYCIN maintains effective antimicrobial action for one to two days after stopping dosage.[7,14] Resurgence of a few viable pathogens, with relapse...and low patient defense against secondary bacterial invasion during the first post-therapy days . . . are largely offset.

MYCIN®

Demethylchlortetracycline Lederle



PERFORMANCE

Susceptibility Tests

Roberts, M. S., *et al.*[25]
New York, N. Y.

Pre-treatment sensitivity tests in 75 genitourinary patients showed DECLOMYCIN Demethylchlortetracycline to be superior against the large majority of organisms and in no instance inferior to tetracycline. DECLOMYCIN apparently has more effective coverage... several strains of *Proteus* and *A. aerogenes* responded.

Tolerance & Toxicity

Boger, W. P., and Gavin, J. J.[3]
Norristown, Pa.

Administration of the recommended 600 mg. (4 capsules) daily for 30 days to a small group of elderly patients revealed no hematologic, hepatic and urinary alteration or other abnormal finding. No clinical side effects were observed.

Gonococcal Infection

Marmell, M., and Prigot, A.[20]
New York, N. Y.

All except two of 63 patients with acute gonorrhea responded promptly to therapy with DECLOMYCIN. Fifteen received 250 mg. q.i.d. for one day, the remainder received 600 or 750 mg. in divided doses over one or two days. No side effects.

General Medicine

Lichter, E. A., and Sobel, S.[19]
Chicago, Ill.

One hundred and sixty-nine patients with various infections showed generally equivalent response to four dosage regimens, including the recommended level. Of 29 pneumococcal pneumonias, all recovered with 15 afebrile in 48 hours or less – except a few patients with preterminal underlying disease. All 42 scarlet fever patients recovered with 32 afebrile in 48 hours or less. Other patients also responded satisfactorily with few exceptions. No blood, liver or kidney toxicity found. G.I. side effects occurred in only 2 per cent at the recommended dosage, or less, and were easily reversible.

Respiratory Infection

Perry, D. M., *et al.*[22]
Seattle, Wash.

Good or fair response in 24 of 30 cases of acute bacterial pneumonia, and in all of six cases of acute bronchitis. Side effects occurred at higher dosage but were uniformly absent when dosage was limited to 600 mg. per day.

Various Infections

Finland, M., *et al.*[7]
Boston, Mass.

Eighty patients with various infections were treated with DECLOMYCIN Demethylchlortetracycline and an equal number with tetracycline. Therapeutic response was indistinguishable between the two groups. However, DECLOMYCIN Demethylchlortetracycline dosage was much lower (50 to 60 per cent of that of tetracycline.) In addition, incidence of side effects with demethylchlortetracycline was only half that experienced with tetracycline.

Pyelonephritis

Vineyard, J. P., *et al.*[29]
Dallas, Tex.

Therapy with DECLOMYCIN was successful in 12 of 13 patients with pyelonephritis. Sterile cultures were obtained in nine patients within six to 14 days. Among the organisms suppressed were strains of *A. aerogenes, E. coli* and paracolon bacillus. In most cases, DECLOMYCIN was used jointly with another antibiotic.

Soft Tissue Infection

Prigot, A., *et al.*[24]
New York, N. Y.

DECLOMYCIN was used alone or auxiliary to surgical measures in 150 cases of acute soft tissue infection, mostly ambulatory. Full resolution of infection was achieved in all cases, average length of treatment being six days. Dosage was 600 or 750 mg. daily. Side effects consisted of transitory G.I. disturbances in three cases.

DECLO

Urinary Infection

Trafton, H. M., and Lind, H. E.[28]
Brookline, Mass.

Clinical response was favorable in a majority of 50 cases of urinary tract infections with relief of symptoms, elimination, or marked reduction, of pyuria and with urine sterilization in some. DECLOMYCIN Demethylchlortetracycline was administered in one-half to one-third the daily milligram level of related antibiotics, for 8 days.

No significant diarrhea occurred in any case although mild nausea and upper G.I. symptoms were fairly common. Phototoxicity occurred in six cases.

Antibiotic-Resistant Infections

Compilation of reports of 210 clinical investigators.[25]

In 570 treated for a great variety of infections, DECLOMYCIN was successful in resolving infection or in effecting marked improvement in 81 per cent, after failure of other antibiotics.

Pediatric Infection

Fujii, R., *et al.*[9]
Tokyo, Japan

Therapeutic results, elicited in 309 pediatric patients with average daily dosage of 15 mg./kg., were equal to those produced by 30 mg./kg. of buffered tetracycline preparations. Satisfactory results were obtained in 75 per cent. No appreciable side effects when 15 mg./kg./day dosage was not exceeded.

Pediatric Infection

Hall, T. N.[12]
San Francisco, Cal.

All eight cases of ophthalmic, respiratory or otic infection responded to four to twelve days of DECLOMYCIN therapy (5 recovered, 2 greatly improved, 1 improved). One skin reaction, in a case receiving the higher trial dosage of 7 mg./lb. daily, occurred.

Pneumonias

Duke, C. J., *et al.*[5]
Washington, D. C.

Results were satisfactory in all 32 cases of acute bacterial penumonia, excepting for two caused by non-susceptible organisms. Over half had been complicated by pleural, suppurative, bronchial, or underlying structural lung problems. Dosage was low. No toxicity found. Acceptance and toleration were excellent.

Intestinal & Respiratory Infection

Hartman, S. A.[13]
Sherman Oaks, Cal.

Six cases of g.i. infection (diverticulitis, ileitis, colitis) responded in three to eight days on the lower milligram intake...even after failure in most with sulfa, neomycin or penicillin-streptomycin. Complete recovery was gained in 5 respiratory cases on a shorter schedule; another withdrew with occurrence of thrush. No other side effects were reported.

Respiratory Infection

Feingold, B. F.[6]
San Francisco, Cal.

All 13 upper or lower respiratory infections demonstrated very good response in 2-3 days on recommended dosage. No side effects were reported.

Various Infections

Compilation of reports of 210 clinical investigators.[25]

Of 1,904 patients with adequate follow-up treated for a wide diversity of infections, 87 per cent were reported as cured or improved. Most patients received one 150 mg. tablet every 6 hours. Therapy usually was for three to eight days. Side effects, mostly referable to the gastrointestinal tract, occurred in 200 patients.

PERFORMANCE

MYCIN®

Demethylchlortetracycline Lederle



PERFORMANCE *(continued)*

Respiratory Infection & Others

Gates, G. E.[11]
South Bend, Ind.

Of 65 cases, predominantly respiratory infections, but including some of cystitis and cellulitis, 50 had a good response, 12 were fair and three were failures. One of the failures was a case of chronic ulcerative colitis and two were respiratory infections. The only complication was a slight vulvular pruritus and burning tongue occurring near the end of a week's treatment of residual pneumonitis.

Pustular Dermatoses

Kanof, N. B., and Blau, S.[16]
New York, N. Y.

Eighty-five per cent of 67 patients responded with excellent or good results on a DECLOMYCIN schedule of one 150 mg. capsule q.i.d. for two to twelve weeks. Three poor responses were related to highly resistant organisms. No pruritus or drug eruptions developed. Only four cases showed nausea or diarrhea in the long therapeutic course.

Surgical Infection

Floyd, R. D., and Anlyan, W. G.[8]
Durham, N. C.

Successful results were generally obtained in 60 patients given 600 mg. DECLOMYCIN daily (or slightly less) for five to 15 days. No infection developed in the clean or contaminated prophylaxis group. Most frank infections responded...including several refractory to previous antibiotics. No toxicity evidenced. Intestinal toleration was excellent.

Wound Infections & Others

Meyer, B. S.[21]
Birmingham, Ala.

Thirty-five cases, chiefly prophylactic, and some traumatic-surgical wound infections were treated usually on one capsule DECLOMYCIN q. 6 h. for two to eight days. Over 80 per cent responded, including one with Pseudomonas etiology. Minor itching or nausea occurred in two; prominent nausea developed in one on a q. 4 h. schedule.

Topical & Wound Infections

Stewart, J.[28]
New Orleans, La.

Of 21 patients followed, 15 completely recovered, four improved in four to 42 days on 600 mg. daily. Seven had not responded to various other therapies. One had *A. aerogenes* predominance, complicated by Proteus and *E. coli*. Cases were traumatic-surgical-topical infections with some respiratory. One questionable reaction of anemia was encountered.

Oral Infection

Arbour, E. F.[1]
New Orleans, La.

Of four patients treated, three responded to one capsule DECLOMYCIN q. 6 h. for three days. No change in one case of chronic proliferating periodontitis. No adverse reactions seen.

Brucellosis

Chávez, Max, G.[3]
Mexico, D. F.

All nine patients infected with *Brucella melitensis* were afebrile on fourth or fifth day of DECLOMYCIN therapy and asymptomatic within 15 days. Treatment lasted for 45 days. No relapses occurred. Hepatic, renal, or hematologic toxicity was not seen. Minor or occasional intestinal reactions in some cases did not require discontinuance.

DECLO

IMPORTANCE...

in the average patient – DECLOMYCIN reduces the possibility of gastrointestinal intolerance and increases the likelihood of an uneventful therapeutic course. Variants of an infecting organism are less likely to survive the high, sustained activity and post-dosage control. Minor or major reverses or "setbacks" during therapy may be avoided. Susceptibility to secondary infection when dosage is terminated is counteracted by the "extra-day" activity.

in mixed infections–DECLOMYCIN provides satisfactory control of conditions involving multiple pathogens. Since organisms vary in sensitivity at given antibiotic levels, the higher DECLOMYCIN activity tends to inhibit a greater proportion of the less susceptible strains. Remission and bacteriologic cure can thus progress at a faster pace.

in the absorption-deficient – The high activity/intake ratio of DECLOMYCIN provides a wider margin of security for those with disturbed or abnormal absorption or with underlying gastrointestinal dysfunction. Inhibitory levels remain more than adequate in most.

under adverse host conditions – In debility, malnutrition, neoplasm, diabetes, or other organic, chronic or underlying disease, DECLOMYCIN may be vital to successful resolution of infection. *Generally in geriatrics,* for the same reason, DECLOMYCIN should often be a broad-spectrum of choice.

if an occasional dose is missed – The sustained action of DECLOMYCIN protects against possible loss of control. In the sleeping patient, an occasional dose may be foregone without adverse effect, while benefits of such rest are gained. Arbitrary rejection of a dose by pediatric or geriatric patients...simple forgetfulness...or postponing a dose will not appreciably reduce antibiotic activity provided these do not occur frequently.

MYCIN®

Demethylchlortetracycline Lederle



IMPORTANCE

DECLOMYCIN®

Demethylchlortetracycline Lederle

a masterpiece of antibiotic design

CAPSULES, 150 mg., bottles of 16 and 100. *Dosage:* Average adult 1 capsule four times daily.

PEDIATRIC DROPS, 60 mg./cc. (custard flavor) in 10 cc. bottle with calibrated dropper. *Dosage:* 1-2 drops (3-6 mg.) per pound body weight per day—divided into 4 doses.

ORAL SUSPENSION, 75 mg./5 cc. teaspoonful (custard flavor) in 2 oz. bottle. *Dosage:* 3-6 mg./lb./day—divided in 4 doses.

REFERENCES: 1. Arbour, E. F.: Clinical report, cited with permission.

2. Boger, W. P., and Gavin, J. J.: Demethylchlortetracycline: Serum Concentration Studies and Cerebrospinal Fluid Diffusion. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

3. Chávez, Max G.: Therapeutic Evaluation of Demethylchlortetracycline in Human Brucellosis. *Ibid.*

4. Clapper, W. E., and Proper, R.: Sensitivities of Clinical Isolates to Demethylchlortetracycline and Tetracycline, and Demethylchlortetracycline Serum Levels in Patients. To be published.

5. Duke, C. J.; Katz, S., and Donohoe, R. F.: Demethylchlortetracycline in the Treatment of Pneumonia. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

6. Feingold, B. F.: Clinical report, cited with permission.

7. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Observations on Demethylchlortetracycline. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

8. Floyd, R. D., and Anlyan, W. G.: Clinical report, cited with permission.

9. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M.; and Ishibashi, T.: Clinical Results with Demethylchlortetracycline in Pediatrics and Comparative Studies with Other Tetracyclines. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

10. Garrod, L. P., and Waterworth, P.: The Relative Merits of the Four Tetracyclines. *Ibid.*

11. Gates, G. E.: Clinical report, cited with permission.

12. Hall, T. N.: Clinical report, cited with permission.

13. Hartman, S. A.: Clinical report, cited with permission.

14. Hirsch, H. A., and Finland, M.: Antibacterial Activity of Serum of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959.

15. Hirsch, H. A.; Kunin, C. M., and Finland, M.: Demethylchlortetracycline—A New and More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. *München med. Wchnschr.* To be published.

16. Kanof, N. B., and Blau, S.: Oral Demethylchlortetracycline in the Treatment of Pustular Dermatoses. Read at Seventh Antibiotic Symposium, Washington, D. C., November 6, 1959.

17. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Men. *Ibid.*, November 5, 1959.

18. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: A New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. *New England J. Med.* 259:999 (Nov. 20) 1958.

19. Lichter, E. A., and Sobel, S.: Serum Antimicrobial Activity and Clinical Observations in 169 Patients with Demethylchlortetracycline. *A.M.A. Arch. Int. Med.* To be published.

20. Marmell, M., and Prigot, A.: The Therapeutic Value of Demethylchlortetracycline in Gonorrhea, Lymphogranuloma Venereum, and Donovanosis. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

21. Meyer, B. S.: Clinical report, cited with permission.

22. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.: Demethylchlortetracycline: A Clinical and Laboratory Appraisal. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

23. Phillips, F. M.: DECLOMYCIN: Seventh Interim Report, Department of Clinical Investigation, Lederle Laboratories, Pearl River, N. Y., December 4, 1959.

24. Prigot, A.; Maynard, A. de L.; and Zach, B.: The Treatment of Soft Tissue Infections with Demethylchlortetracycline. To be published.

25. Roberts, M. S.; Seneca, H., and Lattimer, J. K. Demethylchlortetracycline in Genitourinary Infections. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

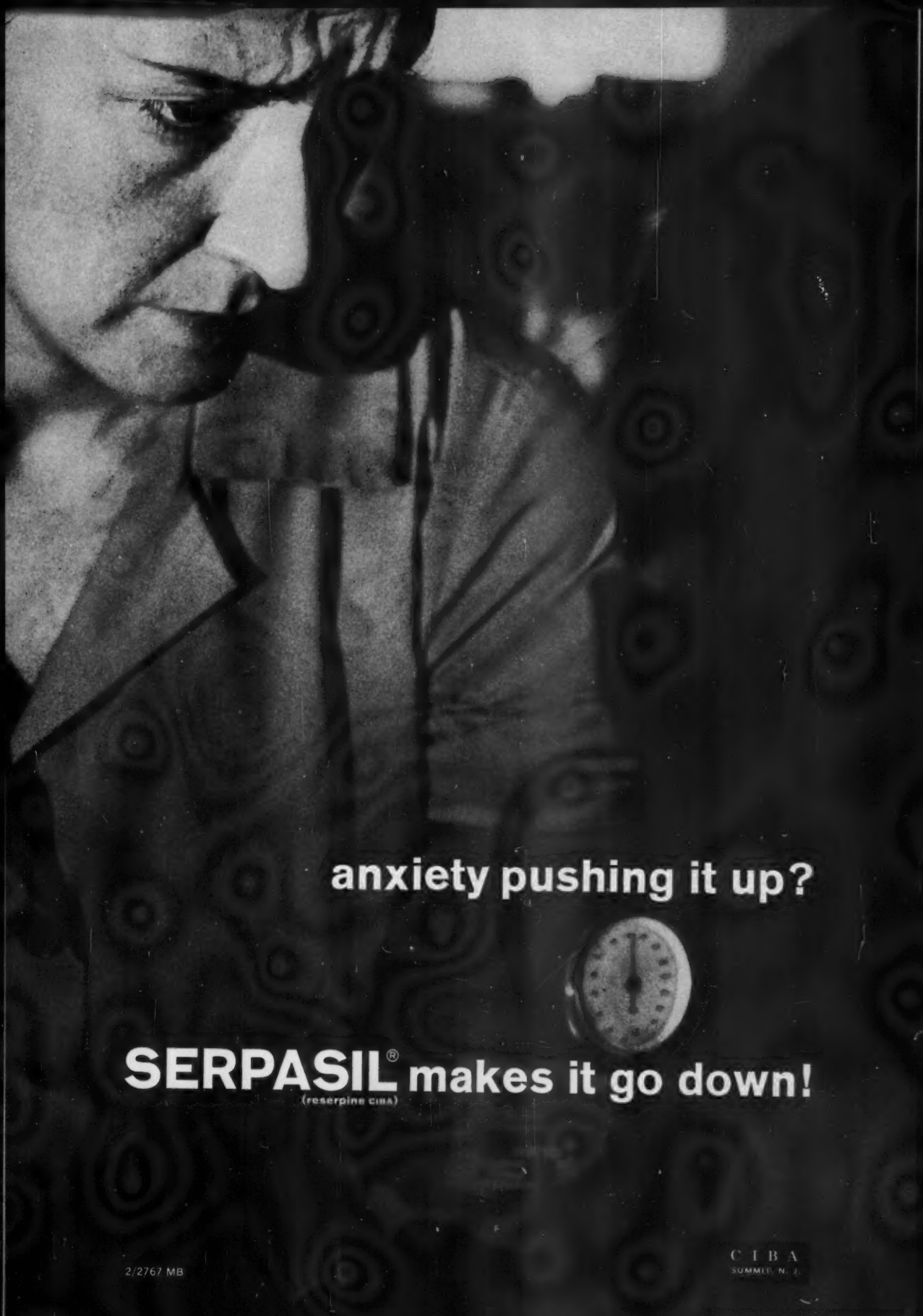
26. Stewart, J.: Clinical Report, cited with permission.

27. Sweeney, W. M.; Hardy, S. M.; Dornbush, A. C., and Ruegsegger, J. M.: Demethylchlortetracycline: A Clinical Comparison of a New Antibiotic Compound with Chlortetracycline and Tetracycline. *Antibiotics & Chemother.* 9:13 (Jan.) 1959.

28. Trafton, H. M., and Lind, H. E.: Demethylchlortetracycline Effectiveness and Tolerances in Urinary Tract Infections. To be published.

29. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: Clinical and Laboratory Evaluation of Demethylchlortetracycline. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.


anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
2/2767 MB
CIBA
SUMMIT, N. J.

The first synthetic penicillin
available
for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATED.

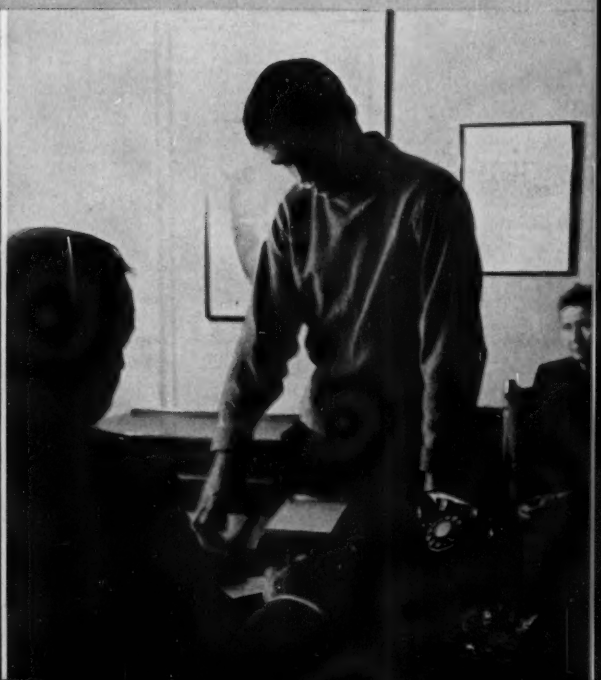
SYNCILLIN

PEAK BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY





. CONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF

SYNCILLIN™

POTASSIUM PENICILLIN-152

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL





FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS... NEW

SYNC

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity.*

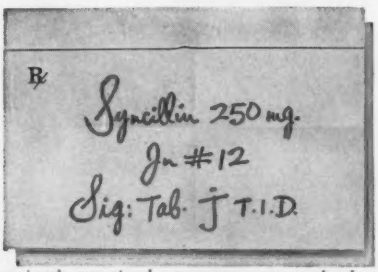
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

I LLIN™

Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

BRISTOL LABORATORIES, Division of Bristol-Myers Company, SYRACUSE, NEW YORK



BAD DIGESTION INCLINES ONE TO SKEPTICISM, INCREDULITY, BREEDS BLACK FANCIES AND THOUGHTS OF DEATH JOSEPH CONRAD

When bad digestion is the consequence of digestive enzyme deficiency, Entozyme may dispel dreary symptoms such as pyrosis, flatulence, belching, and nausea, for it is a natural supplement to digestive enzymes. It provides components with digestive enzyme activity: **Pepsin,** N. F., 250 mg., **Pancreatin,** N. F., 300 mg., and **Bile Salts,** 150 mg. Because Entozyme is actually a tablet-within-a-tablet, these components are freed in the physiological areas where they occur naturally. Entozyme has proved useful in relieving many symptoms associated with cholecystitis, post-cholecystectomy syndrome, sub-total gastrectomy, pancreatitis, infectious hepatitis, and a variety of metabolic diseases.

A. H. ROBINS CO., INC. • RICHMOND 20, VA.

ENTOZYME®



NIAMID®

the mood brightener

eases mental adjustment to menopause

NIAMID brightens the outlook of depressed menopausal patients — gradually helps them become alert, cheerful, relaxed, and better able to cope with their surroundings.

Start with 75 to 100 mg. of NIAMID daily and adjust according to response. In routine use, up to 200 mg. is given. The gradual response to NIAMID may be noted within several days or weeks.

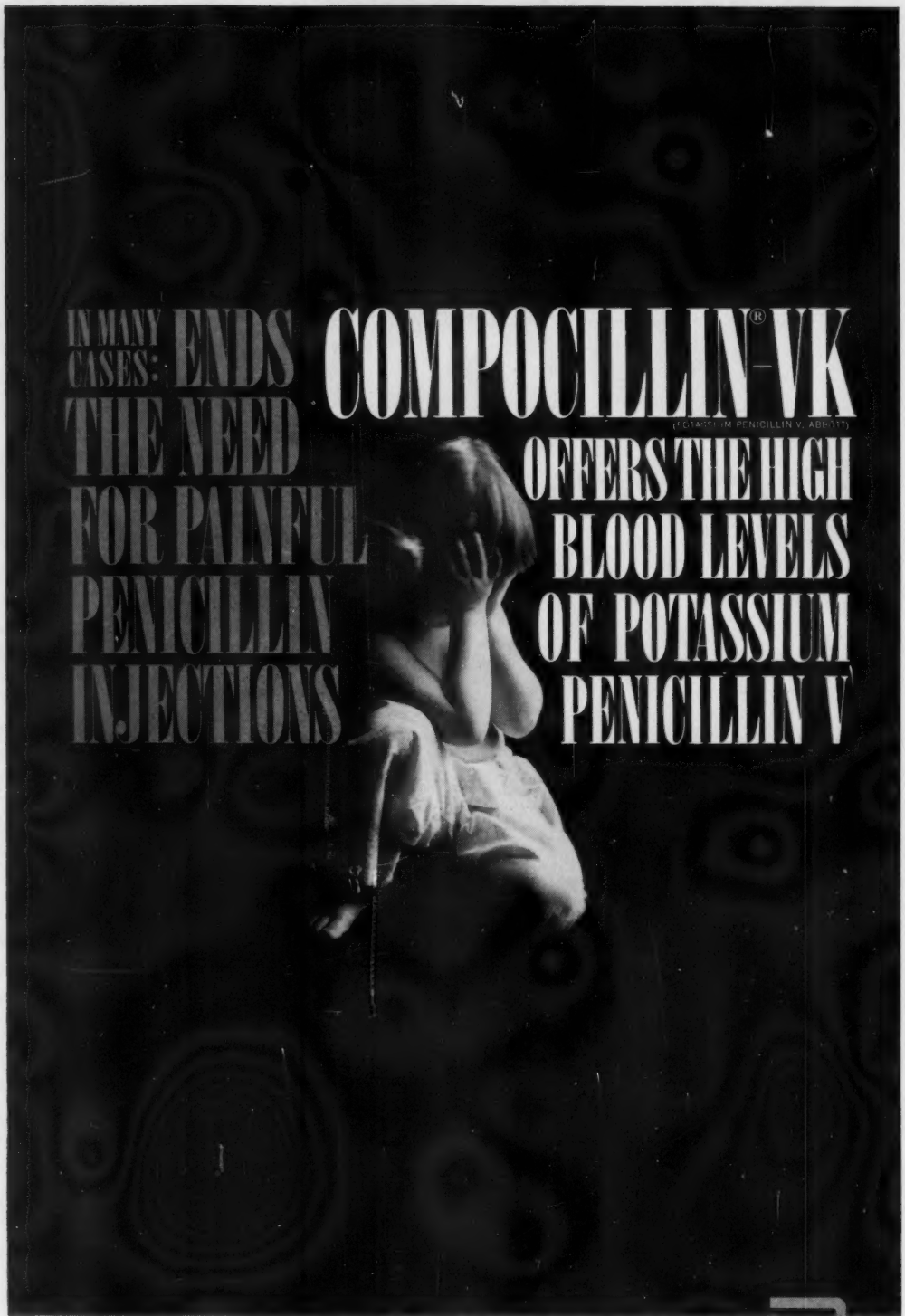
Infrequent, mild side effects may occur but often are lessened or eliminated by dosage reduction. NIAMID has *not* been reported to cause jaundice, disturbances of color vision, ankle edema, or skin eruptions.

NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already prescribed for more than 500,000 patients.

A Professional Information Booklet is available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Pfizer *Science for the world's well-being™*



Available in tiny, easy-to-swallow Filmtabs® and in tasty, cherry-flavored Oral Solution.

001187

®FILMTAB—FILM-SEALED TABLETS, ABBOTT.

ABBOTT



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked,* coated tablets.

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

*TRADE-MARK

CM-1118

New...conservative treatment for muscle and joint disease

- potent...fast relief in acute conditions
- safe...even for prolonged use in chronic cases

low back pain

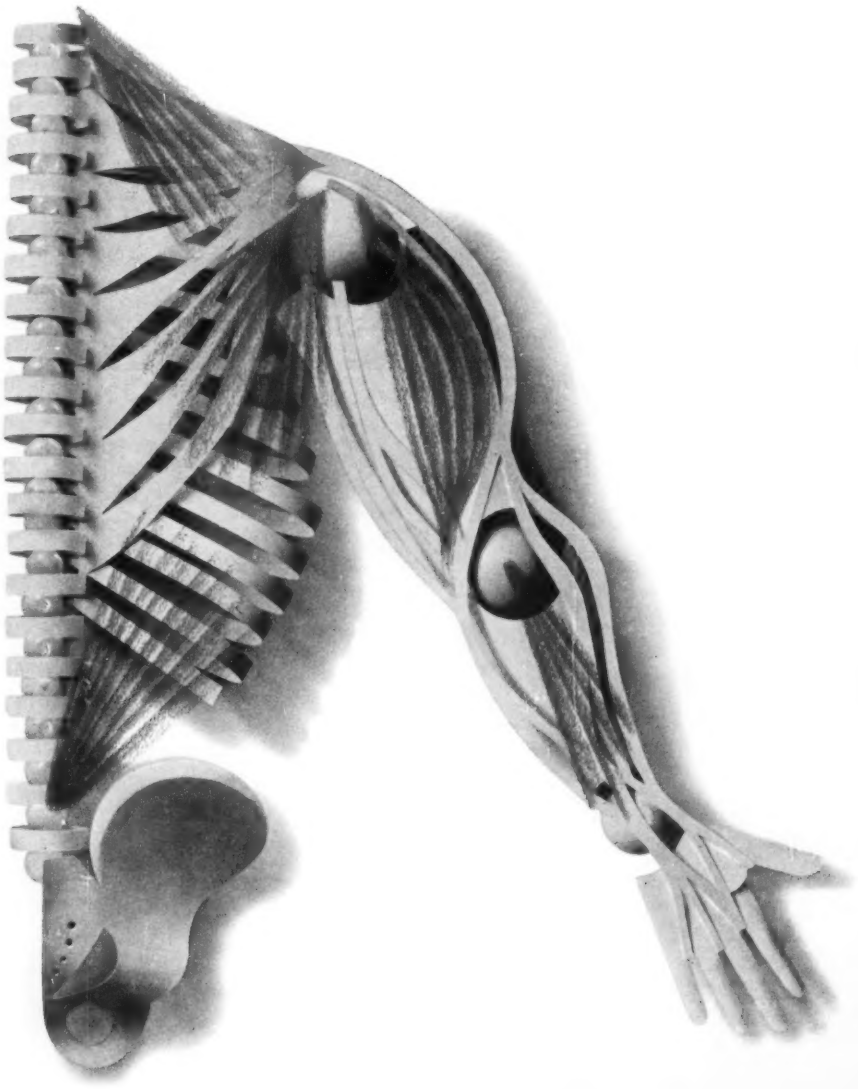
bursitis

strains and sprains

traumatic conditions

arthritis

myalgias



SOMA RELIEVES PAIN in a unique way by modifying central perception of pain without abolishing natural defense reflexes.

SOMA RELAXES MUSCLE SPASM . . . approximately 8 times more potent than meprobamate or mephenesin.

PHYSICIANS' REPORTS:

"Marked pain-relieving effects of the new drug [SOMA] were seen in conditions involving muscle spasm and stiffness, whether acute or chronic. Relief from pain was usually rapid and sometimes dramatic." (90 patients.)
Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)
Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

Notable safety—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

Rapid action—starts to act quickly

Sustained effect—relief lasts up to 6 hours

Easy to use—usual adult dose is one 350 mg. tablet 3 times daily and at bedtime

Supplied—as white, coated, 350 mg. tablets, bottles of 50.
Also available for pediatric use: 250 mg. orange capsules, bottles of 50.

SOMA™

(carisoprodol Wallace)

BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., 76:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., 76:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

Literature and samples on request WALLACE LABORATORIES, New Brunswick, New Jersey

President's Page

LEGACY



Milton A. Darling

President
Michigan State Medical Society

Nearly a year has elapsed since Medicine in Michigan lost one of its most revered members. Perhaps these intervening months have given us a better perspective to evaluate his outstanding contributions to the profession.

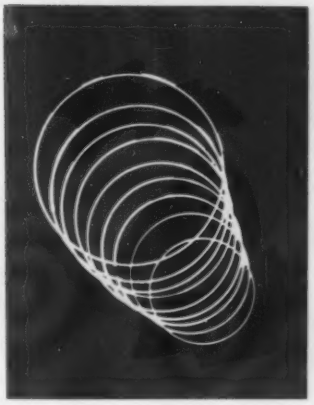
Certainly, we must realize how far-reaching was his influence throughout state and how difficult it is to replace a man of such sterling qualities.

Dedicated, articulate, outspoken—he challenged the opposition when convinced of the justice of his position.

For him, there was no limit of time when a job was to be done. His service to the public in translating Medicine's aims and ideals is impossible to estimate. Unstinting and unpublicized were the many extra hours spent in line of duty.

Obviously, such a schedule demanded a most understanding wife. That "Kitty" is so beloved by her husband's associates is a tribute in itself.

His is a legacy that bears testimony to his remarkable achievements. The many grateful patients whom he benefited; the Medical Society to which he devoted his unusual talents; the public which is wiser for his judgment and counsel; his host of loyal friends—all pay homage to the memory of Dr. L. Fernald Foster.



Challenge of Today

The Michigan State Medical Society held the 1960 Annual County Secretaries-Public Relations Seminar at the Sheraton-Cadillac Hotel in Detroit January 30-31, 1960. The co-chairmen were Ray M. Duffy, M.D., of Pinckney, Chairman of the County Society Secretaries, and R. Wallace Teed, M.D., Ann Arbor, Chairman of the Michigan State Medical Society Public Relations Committee.

Invited were the presidents, presidents-elect, secretaries and editors of all county medical societies. Also invited were the public relations officers of these societies and the public relations committee of the MSMS. There were 249 registered altogether.

Also, in conjunction with the Seminar, there was a county Editors Workshop, held on Saturday preceding the meeting opening.

* * *

A HIGHLIGHT OF THE Seminar was an address by Louis M. Orr, M.D., Orlando, Florida, President of the AMA, discussing "Problems of the Aging—An Immediate Challenge."

Speaking of the Forand-type legislation which the AMA has opposed and classified as vicious legislation, he remarked: "I fear that some proponents are not primarily concerned with the needs of the aged, health or otherwise. My aim is to issue a strong warning to you. This is not a routine rhetorical warning, but rather an urgent call to prevent a medical and national disaster.

"The time has come for every one of us to get out of our offices and laboratories and do something. If we do not act immediately, we are lost. This may sound over-exaggerated to some of you, but I mean it. The leaders and spokesmen of the medical profession and allied groups have done all in their power to fight the Forand Bill. Now it is up to every one of you to get in this fight.

"Please do not think for a moment that passage of the Forand Bill will mean anything less than ultimate government control of medical and health care in the United States. Any element of Forand-type legislation would be a foot in the door which then could be expanded. It is the group of unconcerned physicians that we must alert to the dangers of the Forand Bill. I believe most strongly that only by marshalling every doctor in America, will we be able to successfully battle this dangerous threat."



Arthur L. Tuuri, M.D., *(left)*, of the Mott Foundation, stands with Charles Stuart Mott as he accepts the Distinguished Health Service Award from MSMS President M. A. Darling, M.D. Looking on are MSMS Councilor H. H. Hiscock, M.D., and George E. Anthony, M.D., *(right)*, president of the Genesee County Medical Society.

A PANEL DISCUSSION followed Dr. Orr's address. F. C. Swartz, M.D., Lansing, Chairman of the AMA Committee on Aging, outlined the actual needs and cautioned of the very much over-exaggerated conditions of financial and other desperation of the aged people. He said the group in desperate condition is very small. The majority of those over 65 have established resources which will care for them financially. The desperation of a few is being used to scare the American public into adopting Forand-type legislation. If this is passed it will be following the example of what happened in England.

G. Thomas McKean, M.D., told what is being done and has been done by the Blue Cross-Blue Shield, so that the aged in Michigan may secure prepaid insurance. G. E. Millard, M.D., of Detroit, moderated the afternoon session. The panel discussion was led by P. T. Mulligan, M.D., of Mount Clemens.

* * *

THE AWARDS BANQUET January 30, filled the Grand Ballroom to capacity. The toastmaster was Kenneth H. Johnson, M.D., President-Elect of the MSMS. D. Bruce Wiley, M.D., MSMS Secretary, made announcements of actions taken by The Council and others.

The address of the evening, "Face Up, Speak Up, Shape Up," was by Roger J. Samp, M.D., Madison, Wisconsin.

R. Wallace Teed, M.D., of Ann Arbor, chairman of the MSMS Public Relations Committee, presided at the January 31 morning program. There was a panel discussion led by D. Bruce Wiley, M.D., Secretary, MSMS, as moderator. Taking part were J. C. Heffelfinger, M.D., of Coldwater; J. B. Rowe, M.D., of Flint, and H. C. Tellman, M.D., of Muskegon. A question and answer period followed.

Later in the forenoon Lester P. Dodd, J. D., Legal Counsel, MSMS, talked about "Federal tax aspects of medical society activities."

Milton A. Darling, M.D., MSMS President, and Kenneth H. Johnson, M.D., MSMS President-Elect, discussed the "President's Program" in which the MSMS and other co-operating interests will seek to add useful years to life. At the luncheon, H. J. Meier, M.D., newly elected Chairman of The Council, acted as toastmaster and the main address was given by Professor Walter J. McNerney, Ann Arbor, on the monumental study of Medical and Hospital Care in Michigan.

J. B. Rowe, M.D., of Flint, was elected next year's Chairman of County Society Secretaries.

* * *

The Seminar drew 249 registrations, including:

County Secretaries.— H. E. Schneiter, M.D., (Allegan), Harold Kessler, M.D., (Alpena-Alcona-Presque Isle), D. H. Castleman, M.D., (Barry), H. T. Knobloch, M.D., (Bay-Arenac-Iosco), W. J. Kenfield, M.D., (Berrien), T. B. Mackie, M.D., (Chippewa-Mackinac), J. B. Rowe, M.D., (Genesee), P. H. Ringer, Jr., M.D., (Gratiot-Isabella-Clare), F. M. Wes-

sels, M.D., (Hillsdale), R. C. Dixon, M.D., (Huron), W. D. Cheney, M.D., (Ingham), H. W. Porter, M.D., (Jackson), R. D. Warnke, M.D., (Kalamazoo), Wm. W. Jack, M.D., (Kent), C. E. Conaway, M.D., (Lapeer), Patricia F. Wentz, M.D., (Adrian), R. M. Duffy, M.D., (Livingston), P. V. Kane, M.D., (Macomb), J. E. Walters, M.D., (Mecosta-Osceola-Lake), G. H. Hopson, M.D., (Menominee), R. A. Frary, M.D., (Monroe), H. Clay Tellman, M.D., (Muskegon), R. W. Emerick, M.D., (Newaygo), P. A. Dosch, M.D., (North Central), T. B. Kirk, M.D., (Northern Michigan), J. A. Read, M.D., (Oakland), W. F. Strong, M.D., (Ontonagon), Michael Raftery, M.D., (St. Clair), A. B. Thompson, M.D., (Saginaw), A. E. Parks, M.D., (Van Buren), G. H. Bauer, M.D., (Washtenaw), H. M. Fuller, M.D., (Wayne).

County Presidents.—C. S. Wilson, M.D., (Alpena-Alcona-Presque Isle), R. G. Finnie, M.D., (Barry), C. W. Reuter, M.D., (Bay-Arenac-Iosco), E. D. Hamilton, M.D., (Branch), C. H. Clausen, M.D., (Chippewa-Mackinac), G. E. Anthony, M.D., (Genesee), J. H. Bergin, M.D., (Gratiot-Isabella-Clare), J. R. Lentini, M.D., (Kent), C. L. Cook, M.D., (Lenawee), M. S. Reizen, M.D., (Macomb), L. A. Hickox, M.D., (Mecosta-Osceola-Lake), C. H. Willison, M.D., (Midland), G. B. Loan, M.D., (Monroe), A. L. Benedict, M.D., (Muskegon), Duane E. Smith, M.D., (Sanilac), J. D. Cantwell, Jr., (St. Clair), H. R. Weisheit, M.D., (St. Joseph), M. R. Weed, M.D., (Wayne), G. P. Moore, M.D., (Wexford-Missaukee).

County Presidents-Elect.—J. E. Mahan, M.D., (Allegan), F. W. Baske, M.D., (Genesee), David Kahn, M.D., (Ingham), L. R. Banner, (Kalamazoo), Jack Hoogerhyde, M.D., (Kent), K. H. Whitehouse, M.D., (Lenawee), Victor Curatolo, M.D., (Macomb), M. B. Meengs, M.D., (Muskegon), E. F. Crippen, M.D., (Northern Michigan), D. J. Millard, M.D., (Van Buren), O. K. Engelke, M.D., (Washtenaw), D. I. Sugar, M.D., (Wayne).

County Bulletin Editors.—J. C. Heffelfinger, M.D., (Branch), P. K. Stevens, M.D., (Genesee), J. L. Isbister, M.D., (Ingham), L. A. Dick, M.D., (Kalamazoo), W. J. Hanley, M.D., (Muskegon), H. L. Miller, M.D., (Oakland), R. J. Gerard, M.D., (Saginaw), Wm. J. Stapleton, Jr., M.D., (Wayne), (Associate Editor), C. W. Sellers, M.D., (Wayne), (Associate Editor), W. G. White, M.D., (Muskegon), (Associate Editor).

Public Relations Chairmen.—G. L. Hagelshaw, M.D., (Bay-Arenac-Iosco), A. B. Gwinn, M.D., (Barry), R. E. Reagan, M.D., (Berrien), G. T. Kelleher, M.D., (Calhoun), F. W. Smith, M.D., (Clinton), C. L. Hoogerland, M.D., (Gratiot-Isabella-Clare), D. B. Hiscoe, M.D., (Ingham), R. J. Kobs, M.D., Jackson), E. L. Stone, M.D., (Jackson), R. H. Hume, M.D., (Kalamazoo), R. F. Hauer, M.D., (Livingston), P. C. Hopson, M.D., (Menominee), L. E. Grate, M.D., (Northern Michigan), M. G. Prosser, M.D. (Oakland), S. W. Kuipers, M.D., (Ottawa), W. G. Mason, M.D., (Saginaw), W. J. Dinnen, M.D., (St. Clair), H. C. Johnson, M.D., (Van Buren), E. H. Place, M.D., Pro Tem (Washtenaw), S. E. Chapin, M.D., (Wayne).

MSMS Council.—O. J. Johnson, M.D. (Bay), H. J. Meier, M.D., (Branch), Editor Wilfrid Haughey, M.D., (Calhoun), E. S. Oldham, M.D., (Gratiot-Isabella-Clare), T. P. Wickliffe, M.D., (Houghton-Keweenaw-Baraga), K. H. Johnson, M.D., (Ingham), O. B. McGillicuddy, M.D., (Ingham), Wm. A. Scott, M.D., (Kalamazoo), C. Allen Payne, M.D., (Kent), D. Bruce Wiley, M.D., (Macomb), Wm. M. LeFevre, M.D., (Muskegon), G. B. Saltonstall, M.D., (Northern Michigan), C. N. Hoyt, M.D., (St. Clair), L. J. Bailey, M.D., (Wayne),



H. Marvin Pollard, M.D., *(left)*, Ann Arbor, is given his President's Award by Doctor Darling as distinguished guest Louis M. Orr, M.D., president of the American Medical Association, looks on.



Reed M. Nesbit, M.D., *(left)*, Ann Arbor, takes an advance glance at his President's Award which was presented formally at the Banquet by President M. A. Darling, M.D. All awards were framed after presentation according to recipient's preference.



Representing the Muskegon *Chronicle* was Bruce McCrea who attended the Awards Banquet on behalf of the publisher. The award cited the newspaper for its contribution to the success of the 1959 polio immunization campaign in Muskegon County.

William Bromme, M.D., (Wayne), Milton A. Darling, M.D., (Wayne), G. Thomas McKean, M.D., (Wayne), A. E. Schiller, M.D., (Wayne).

Executive Secretaries.—Ruth Simmons, (Genesee), Jack Kantner, (Ingham), R. L. Warnshuis, (Kent), Mrs. F. H. Bartlett, (Muskegon), Mrs. Mary G. Haines, (Oakland), Else Kolhede, (Wayne).

Woman's Auxiliary Representatives.—Mrs. Ross V. Taylor, (Jackson), Mrs. Paul Ivkovich, (Mecosta-Osceola-Lake), Mrs. Harold H. Gay, (Midland), Mrs. C. I. Owen, (Wayne).

RECORD OF ATTENDANCE AT MSMS COUNTY SECRETARIES-PUBLIC RELATIONS SEMINAR

County or District Medical Society	*President*	*President-Elect*	*Secretary*	*County PR Chairmen*	*Editor*	*MSMS Council*	*MSMS PR Committee*	*Executive Secretary*
Allegan	O	X	X	O	N	N	N	N
Alpena-Alcona-Presque Isle	X	O	X	O	N	N	X	N
Barry	X	N	X	X	N	N	O	N
Bay-Arenac-Iosco	X	N	X	O	O	X	O	N
Berrien	O	O	X	X	O	N	N	N
Branch	X	O	O	O	X	X	O	N
Calhoun	O	O	O	X	O	X	X	N
Cass	O	N	O	N	N	N	N	N
Chippewa-Mackinac	X	O	X	O	N	O	O	N
Clinton	O	O	O	X	N	N	O	N
Delta-Schoolcraft	O	O	O	N	N	N	X	N
Dickinson-Iron	O	O	O	O	O	N	O	N
Eaton	O	O	O	N	N	N	N	N
Genesee	X	X	X	O	X	O	XXX	X
Gogebic	O	O	O	O	N	N	N	N
Grand Traverse-Leelanau-Benzie	O	O	O	O	O	O	O	N
Gratiot-Isabella-Clare	X	O	X	X	N	X	X	N
Hillsdale	O	O	X	N	N	N	N	N
Houghton-Baraga-Keweenaw	O	O	O	O	N	X	O	N
Huron	O	O	X	O	N	N	O	N
Ingham	O	X	X	X	X	X	X	X
Ionia-Montcalm	O	O	O	O	N	N	N	N
Jackson	O	O	X	XX	N	N	N	N
Kalamazoo	O	X	X	X	X	X	O	N
Kent	X	X	X	O	O	XO	X	X
Lapeer	O	N	X	O	N	N	O	N
Lenawee	X	X	O	O	O	N	N	N
Livingston	O	O	X	X	N	N	X	N
Luce	O	O	O	N	N	N	N	N
Macomb	X	X	X	O	N	X	O	N
Manistee	O	X	O	O	N	N	N	N
Marquette-Alger	O	O	O	O	N	N	O	N
Mason	O	N	O	O	N	N	N	N
Mecosta-Osceola-Lake	X	O	X	O	N	N	N	N
Menominee	O	O	X	X	N	N	N	N
Midland	X	O	O	O	N	N	N	N
Monroe	X	O	X	X	N	N	O	N
Muskegon	X	X	X	X	X	X	X	X
Newaygo	O	O	X	O	N	N	N	N
North Central	O	O	X	N	N	N	O	N
Northern Michigan	O	X	X	X	X	X	OO	N
Oakland	O	O	X	X	X	O	OO	X
Oceana	O	N	O	N	N	N	N	N
Ontonagon	O	O	X	O	O	N	O	N
Ottawa	O	O	O	X	N	N	N	N
Saginaw	O	O	X	X	X	N	XO	O
St. Clair	X	O	X	X	X	X	X	N
St. Joseph	X	O	O	O	N	N	X	N
Sanilac	X	O	O	O	N	N	N	N
Shiawassee	O	O	O	O	N	N	X	N
Tuscola	O	O	O	N	O	N	N	N
Van Buren	O	X	X	X	N	N	N	N
Washtenaw	O	X	X	X	O	OO	XX	O
Wayne	X	X	X	X	O	XX XXX	XX XX OOOO	X
Wexford-Missaukee	X	N	O	O	N	N	N	N

Others present at the Seminar were: Woman's Auxiliary representatives, 4; Michigan State Medical Assistants Society representatives, 2; Michigan Medical Service representatives, 12; Michigan Hospital Service representatives, 4; Program Participants, 18; guests 76.

X Present O Absent N None

Michigan State Medical Assistants Society Representatives.—Reta V. Stahl, (Albion), Beth E. Brin, (Saginaw).

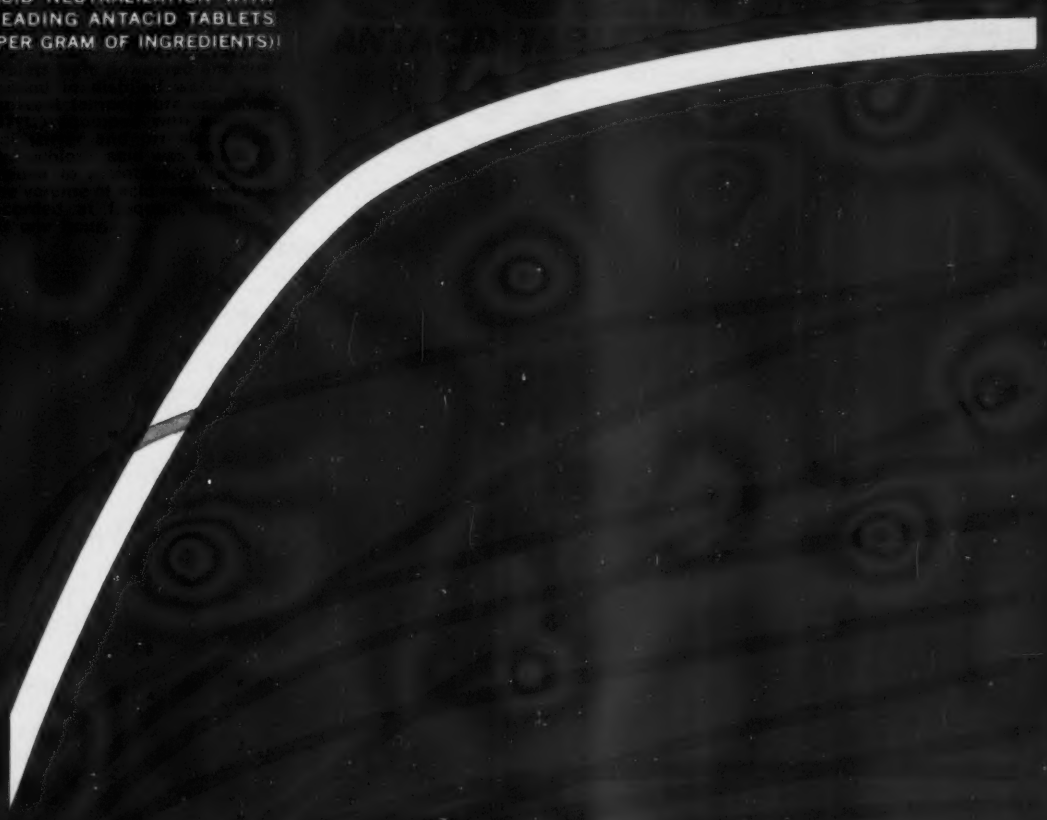
Public Relations Committee.—R. W. Teed, M.D., Chairman, (Washtenaw), J. W. Bunting, M.D., (Alpena-Alcona-Presque Isle), H. C. Hansen, M.D., (Calhoun), W. G. Gamble, M.D., (Bay-Arenac-Iosco), J. R. Dehlin, M.D., (Delta-Schoolcraft), W. Z. Rundles, Sr., M.D., (Genesee), C. K. Stroup, M.D., (Genesee), R. E. Anderson, M.D., (Genesee), H. G. Benjamin, M.D., (Kent), David Kahn, M.D., (Ingham), E. W. Schnoor, M.D., (Kent), S. L. Hoffman, M.D., (Livingston), H. D. Dykhuizen, M.D., (Muskegon), F. E. Luger, M.D., (Saginaw), Wm. J. Dinnen, M.D., (St. Clair), J. M. Jacobowitz, M.D., (St. Joseph), C. L. Weston, M.D., (Shiawassee), J. M. Sheldon, M.D., (Washtenaw), S. E. Chapin, M.D., (Wayne), L. T. Henderson, M.D., (Wayne), E. C. Long, M.D. (Wayne), G. L. Millard, M.D., (Wayne).

Participants on the Program.—Milton A. Darling, M.D., (Detroit), Lester P. Dodd, LL.B., (Detroit), Ray M. Duffy, M.D., (Pinckney), Stephen E. Gavin, Jr., M.D., (Madison, Wisconsin), J. C. Heffelfinger, M.D., (Coldwater), Kenneth H. Johnson, M.D., (Lansing), G. Thomas McKean, M.D., (Detroit), Professor W. J. McNerney, (Ann Arbor), G. E. Millard, M.D., (Detroit), P. T. Mulligan, M.D., (Mt. Clemens), Louis M. Orr, M.D., (Orlando, Florida), J. B. Rowe, M.D., (Flint), R. J. Samp, M.D., (Madison, Wisconsin), A. E. Schiller, M.D., (Detroit), F. C. Swartz, M.D., (Lansing), R. Wallace Teed, M.D., (Ann Arbor), H. Clay Tellman, M.D., (Muskegon), D. Bruce Wiley, M.D., Utica)

Guests.—Henry Alexander, (Detroit), Mrs. R. E. Anderson, (Flint), Mrs. L. R. Banner, (Kalamazoo), Rudy Bolich, (Ironwood), W. W. Boyles, (Detroit), Russell J. Burns, (Ann Arbor), Mrs. J. D. Cantwell, Jr., (Port Huron), Richard N. Capuano ,(Detroit), H. E. Cartwright, (Chicago), Mrs. D. H. Castleman, (Hastings), Mrs. C. L. Cook, (Tecumseh), Mrs. Chas. E. Conaway, (Lapeer), Mrs. Victor Curatolo, (Macomb), Mrs. Milton A. Darling, (Detroit), Mrs. James R. Dehlin, (Gladstone), Mrs. Wm. J. Dinnen, (Port Huron), Mrs. Lester P. Dodd, (Detroit), Mr. and Mrs. John A. Doherty, (East Lansing), Mrs. P. A. Dosch, (Grayling), Mrs. R. W. Emerick, (Fremont), Mrs. O. K. Engelke (Washtenaw), Mr. and Mrs. Lee E. Feldkamp, (Plymouth), Mrs. R. G. Finnie, (Hastings), Mr. Jim Foley, (Detroit), Mrs. R. A. Frary, (Monroe), Mrs. W. G. Gamble (Bay City), Everette Gustafson, M.D., (Pontiac), Dr. and Mrs. W. W. Hammond, Jr., (Plymouth), Mrs. H. C. Hansen, (Calhoun), S. T. Harris, M.D., (Ypsilanti), D. B. Heilbronn, M.D., (Saginaw), Mrs. L. A. Hickox, (Big Rapids), Mrs. D. B. Hiscoe (Lansing), Mrs. Jack Hoogerhyde, (Grand Rapids), Wm. N. Hubbard, (Ann Arbor), Paul Ivkovich, M.D., (Reed City), Mrs. John M. Jacobowitz, (Three Rivers), Mrs. H. C. Johnson, (Paw Paw), Mrs. O. J. Johnson, (Bay City), Mrs. W. John Kenfield, (Benton Harbor), Mrs. Harold Kessler, (Alpena), Carl G. King, (Saginaw), Peter E. Klein, (Detroit), Mrs. R. J. Kobs, (Jackson), Mrs. Wm. M. LeFevre, (Muskegon), Mrs. G. B. Loan, (Monroe), Miss E. K. Longley, (Ludington), Mrs. T. B. Mackie, (Sault Ste. Marie), Mrs. Wm. G. Mason, (Saginaw), W. G. McClimans, (Grand Rapids), Mrs. Bruce McCrea, (Muskegon), R. H. McDonough, (Grand Rapids), Mrs. M. B. Meengs, (Muskegon), Mrs. David J. Millard, (Paw Paw), Mrs. G. P. Moore, (Cadillac), John Nelson, (Pontiac), J. Irvin Nichols, (Lansing), C. I. Owen, M.D., (Detroit), Tom Paton, (Detroit), Mrs. C. Allen Payne, (Grand Rapids), H. G. Pearce, (Detroit), Mrs. E. H. Place, (Ann Arbor), Mrs. M. G. Prosser, (Pontiac),

(Continued on Page 382)

More gastric acid neutralized faster...with new



GREATLY HEIGHTENED REACTIVITY to acid characterizes the action of New Creamalin Antacid Tablets.[1,2] They act faster and longer than other leading tablets and neutralize considerably more acid.[1] These tablets provide virtually the same effects as a liquid[2] with the convenience of a tablet. New Creamalin tablets give faster, greater and more prolonged relief.

NOT CONSTIPATING, New Creamalin Antacid Tablets will not produce "acid rebound" or alkalosis. They have a pleasant taste.

Creamalin, trademark reg. U. S. Pat. Off.

EACH NEW CREAMALIN ANTACID TABLET contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol), with 75 mg. of magnesium hydroxide.

Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

How Supplied: Bottles of 50, 100, 200 and 1000.

1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

Winthrop
LABORATORIES
New York 18, N. Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

Challenge of Today

(Continued from Page 380)

Mrs. Michael Raftery, (Port Huron), D. D. Randall, (Flint), Mrs. R. E. Reagan, (Benton Harbor), Wm. J. Regan, M.D., (Ann Arbor), Mrs. M. S. Reizen, (Warren), Mrs. C. W. Reuter, (Bay City), Chuck Rickett, (Traverse City), Mrs. J. B. Rowe, (Flint), Mrs. G. B. Saltonstall, (Charlevoix), Helen Schick, (Detroit), E. W. Scruby, (Kalamazoo), Mrs. J. M. Sheldon, (Ann Arbor), Mrs. Duane Smith, (Brown City), Louise Smith, (St. Johns), R. H. Stauch, (Detroit), S. D. Steiner, M.D., (Detroit), Mrs. E. L. Stone, (Jackson), R. V. Taylor, M.D., (Jackson), Mrs. A. B. Thompson, (Saginaw), Kay Topp, (Saginaw), Franz Topol, (Flint), Marguerite M. Vergosen, (Detroit), Robert R. Wadlund, M.D., (Howell), Mrs. R. D. Warnke, (Kalamazoo), J. M. Wellman, M.D., Lansing), Mrs. C. L. Weston, (Owosso), Mrs. D. Bruce Wiley, (Utica), Mrs. C. H. Willison, (Midland).

Social Workers Hear Doctors in Flint

Relationships of the medical profession to social work was discussed by a panel of physicians before a Social Workers meeting in January in Flint.

On the panel were Doctors J. C. Benson, R. G. Sandberg, H. B. Elliott, and M. G. Fee. Moderator was G. E. Anthony, M.D., president of the Genesee County Medical Society

Macomb CMS Honors 45-Year Practitioners

In January, the Macomb County Medical Society honored two of its members who have been in practice for 45 years. Milton C. Smith, M.D., of Mt. Clemens, and Allan B. Bower, M.D., of Armada, were feted at the Society's monthly dinner meeting.

Oakland Emergency Call System Draws Accolade

When the Oakland County Medical Society announced the inauguration of a new Emergency Call System in early December, area newspapers hailed the action of the county's 400 doctors. The Society's Public Relations Chairman Everette Gustafson, M.D., explained in news releases that two doctors would be on duty in each 24-hour alert period, to handle any emergency in which the family doctor could not be located. When called, the answering service will contact one of the doctors on duty, who will return the call at once, either prescribing a medication, making a home visit, or arranging for hospital admission.

Offer Keogh-Simpson Films

County societies in Michigan may be interested in showing a film on the Keogh-Simpson Bill. The American Thrift Assembly, Room 612, 1025 Connecticut Avenue, N.W., Washington 6, D. C., offers three 10-minute, 16-millimeter films which feature interviews with (1) Smathers, (2) Moss and Smathers, and (3) Allott and Simpson.

Genesee Cancer Clinic April 13

Outstanding speakers will be offered at the Genesee County Annual Cancer Clinic, April 13. The scientific program will be held at the Merliss Brown Auditorium at Hurley Hospital.

George E. Anthony, Genesee president, will begin the program at 9:30 a.m. The morning speakers will include John R. McDonald, M.D., Detroit, on "The Pathology of Mediastinal Tumors;" Thomas H. Burford, M.D., St. Louis, on "The Surgery of Mediastinal Tumors," and Henry J. Jaffe, M.D., New York, on "Diagnostic Problems Relating to Certain Primary Bone Tumors."

Afternoon speakers are Cushman Haagensen, M.D., New York, on "The Surgery of Breast Cancer;" Ruth J. Guttmann, M.D., New York, on "Radiotherapy for Cancer of the Breast," and Henry T. Randall, M.D., on "Endocrine Management of Breast Cancer."

(Continued on Page 384)

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

March 21-22	Michigan Conference on Comparative Medicine	East Lansing
April 7	Ingham County Medical Society Spring Clinic	Lansing
April 13	Genesee County Cancer Day	Flint
May 4	Wayne State University Clinic Day and Alumni Reunion	Detroit
June 17-18	Upper Peninsula Medical Society	Escanaba
July 28-29	Coller-Penberthy Clinic	Traverse City



whenever there is inflammation, swelling, pain

VARIDASE®
STREPTOKINASE-STREPTODORNASE LEDERLE
BUCCAL *Tablets*

conditions for a fast comeback...
as in acute hemorrhoids...

SUNDAY, 9 A.M.: VARIDASE for painful thrombotic hemorrhoid. 2:30 P.M.: pain greatly reduced, less swelling and inflammation.

MONDAY: size down to small tab; acute inflammation disappeared.*

VARIDASE activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement; swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster... in trauma or infection.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.
Supplied: Boxes of 24 and 100 tablets

*Peterman, R. A.: Clinical report cited with permission.

Lederle

LEDERLE LABORATORIES,
a Division of American Cyanamid Company, Pearl River, N. Y.

(Continued from Page 382)

List Ingham Clinic Speakers

The 32nd Annual Spring Clinic will be sponsored by the Ingham County Medical Society at the Lansing Civic Center small auditorium April 7.

The program will begin at 9:30 a.m. with the morning addresses on "Space Medicine" by Col. John Stapp, M.D., Dayton; "The Treatment of Cancer of the Cervix" by Juan A del Regato, M.D., Colorado Springs, and "Office Recognition of Some Commonly Misdiagnosed Endocrinopathies in Children" by John D. Crawford, M.D., Boston.

The next series of speakers beginning with luncheon will cover "Malpractice" by Russell S. Fisher, M.D., Baltimore; "Systematic Approach to Diagnosis of Body Fluid Disturbances" by W. D. Snively, Jr., M.D., Evansville; "Choosing the Right Prostatic Operation" by C. Donald Creevy, M.D., Minneapolis; "Pediatric Surgery" by John Keeley, M.D., Chicago, and "Impotency and Frigidity" by Donald W. Hastings, M.D., Minneapolis. The program will adjourn at 5:25 p.m.

Perry C. Spencer, M.D., Ingham president, will preside.

Do You Know . . .

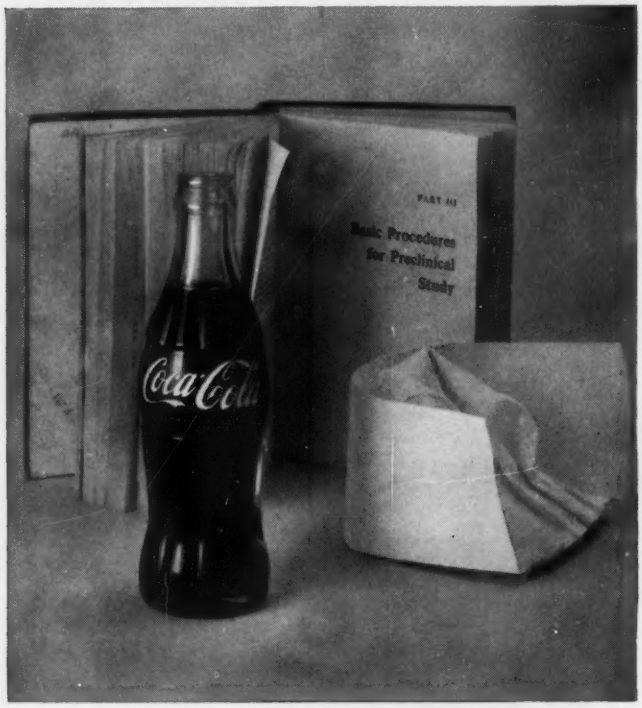
Your MSMS Annual Session is less than six months away?

September 27-30, 1960
DETROIT

YOU HAVE A DATE!

MORE SOCIETY NEWS . . .

In addition to the MSMS news in this section, further information from the Annual Session of The Council appears on Pages 460-474.



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.



When blood pressure must come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

SERPASIL®-APRESOLINE®

hydrochloride (reserpine and hydralazine hydrochloride CIBA)

2/2765MR

CIBA
SUMMIT, N. J.



Just a wish turns old to new

Modernize without capital outlay on the G-E Maxiservice® x-ray rental plan

Think of renting x-ray equipment as conveniently as you subscribe for telephone service! Exclusive Maxiservice rental plan offers all new-model G-E x-ray units . . . takes no capital from your savings. Makes it worry-free to "go modern" in x-ray and always stay that way. For complete details, contact your G-E x-ray representative, listed below.

All this for one monthly fee —

- Modern x-ray equipment, free of obsolescence worries
- Comprehensive coverage: periodic inspection, maintenance, tubes, parts, emergency repairs
- Freedom to add or replace equipment as improvements appear
- Full property insurance on equipment — in case of accidental damage or loss, G.E. repairs or replaces equipment
- Local property taxes paid in full

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

DETROIT
18801 W. 7 Mile Rd. • KEnwood 7-6300

DULUTH
928 E. 2nd St. • RAndolph 4-8648

RESIDENT REPRESENTATIVES

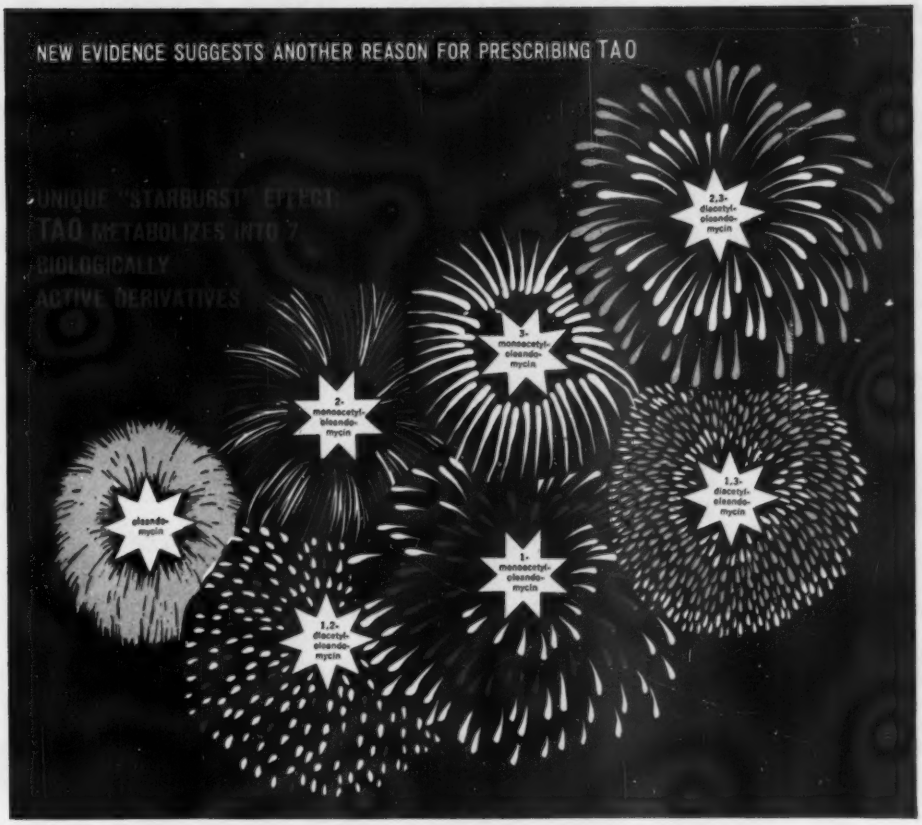
EAST GRAND RAPIDS
J. E. TIPPING, 1044 Keneberry Way, S.E. • GLendale 2-5283

FLINT
E. F. PATTON, 1202 Milbourne • FLint 5-0842

GREEN BAY
J. J. VICTOR, 1242 S. Quincy St. • HEmlock 5-5742

JACKSON
E. J. RHINEHART, 126 Birdsell St. • STate 9-6662

Say you saw it in the Journal of the Michigan State Medical Society



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of *in vivo* and *in vitro* biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which remain active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of *Staph. aureus*.

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. **TAO®-AC:** TAO analgesic, antihistaminic compound. **TAOMID®:** TAO with triple sulfas. **Intramuscular or Intravenous:** in clinical emergencies. Prescription only.

1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

designed for superior control of common Gram-positive infections

TAO®

(triacetyloleandomycin)

Capsules/Oral Suspension



℞ **New York 17, N. Y.**
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Tofrānil®

brand of imipramine HCl

in depression

lights the road to recovery
in 80 per cent of cases

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic . . .
not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

Detailed Literature Available on Request.

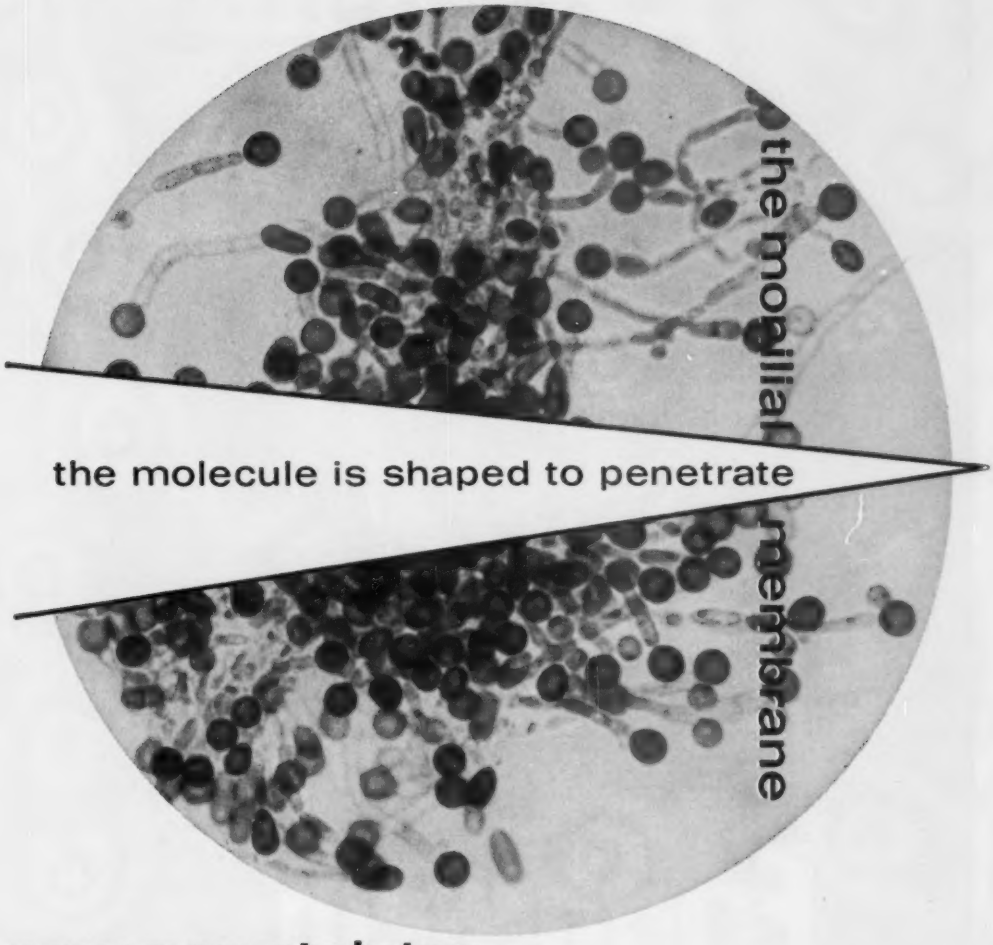
Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

Geigy, Ardsley, New York

Geigy

TO4-60



new non-staining SPOROSTACIN® Chlordantoin Cream

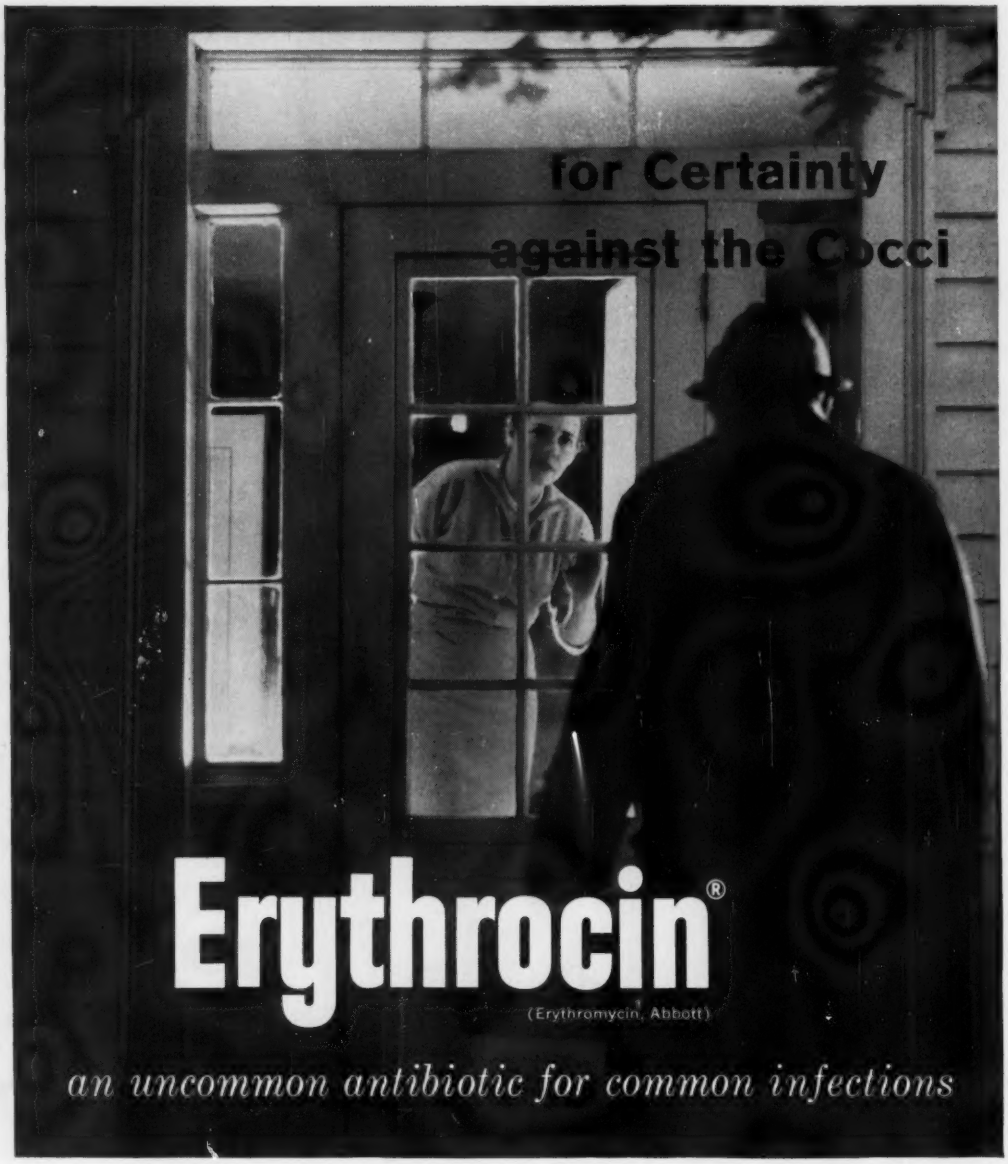
chemically different, non-staining, "shaped charge" monilicide
soothing, odorless, white

Ortho

Exceptional fungicidal activity—The unique "shaped charge" molecular structure of the active agent in SPOROSTACIN Cream facilitates penetration of the fatty barrier of the fungous cell membrane for exceptional fungicidal activity.

Outstanding clinical results—"The use of this new compound, chlordantoin, in the treatment of vaginal candidiasis [moniliasis] offers the advantages of simplicity, patient acceptance, and rapid relief of symptoms, together with a high percentage of culture-free cures."

*Lapan, B.: Am. J. Obst. & Gynec. 78:1320, 1959.



Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

ABBOTT

®FILMTABS—FILM-SEALED TABLETS, ABBOTT; U.S. PAT. NO. 2,981,085

909132

Synonyms for Pain Relief...

'TABLOID' 'EMPIRIN' COMPOUND®

Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½

'TABLOID' 'EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

No. 1
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ⅛

No. 2
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ¼

No. 3
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ½

No. 4
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. 1

*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

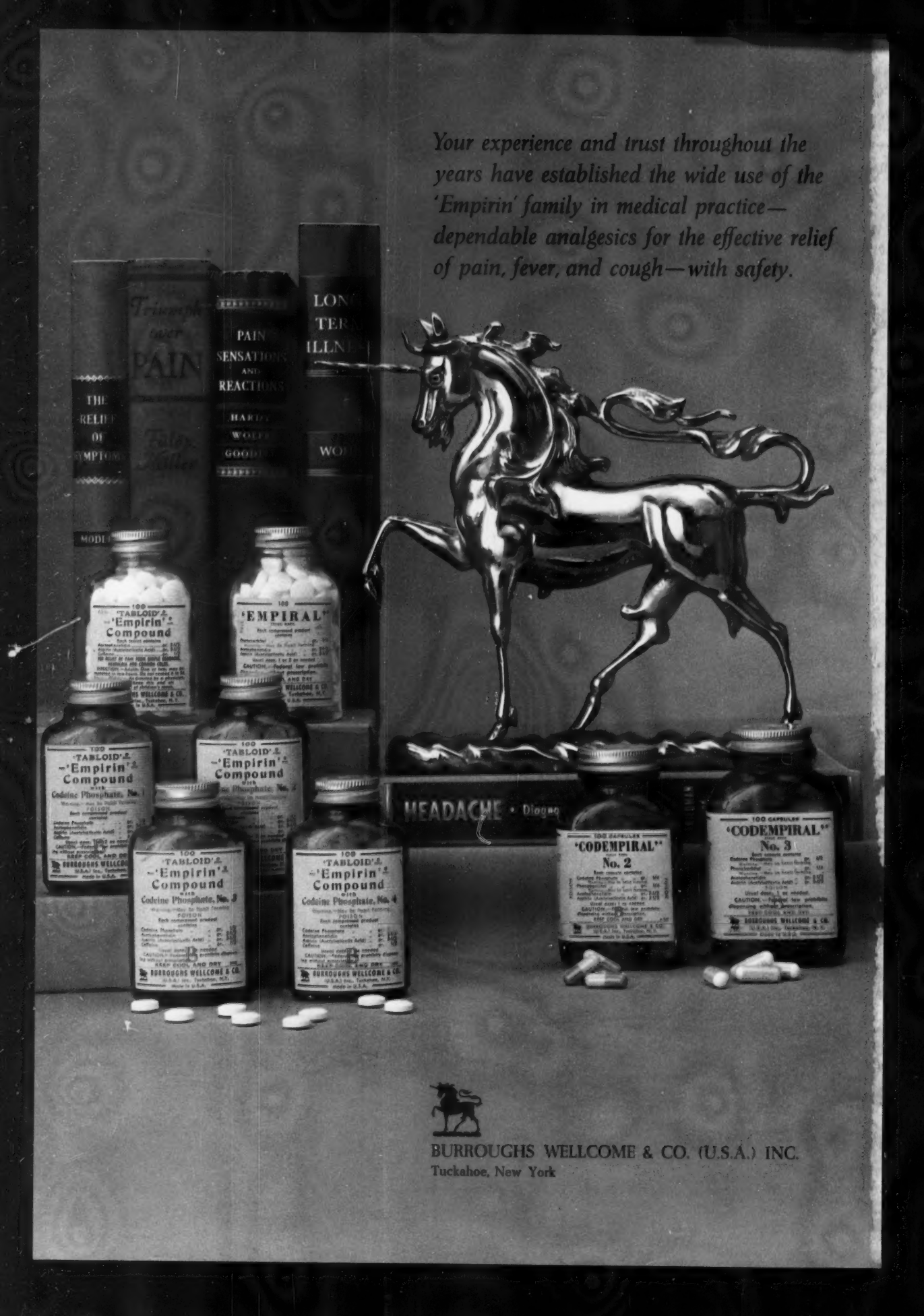
IN
simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis/bursitis

relief of pain of all degrees of severity up to that which requires morphine

AND IN
fevers
dry, unproductive coughs



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York


Your experience and trust throughout the years have established the wide use of the 'Empirin' family in medical practice—dependable analgesics for the effective relief of pain, fever, and cough—with safety.
PAIN SENSATIONS AND REACTIONS
'TABLOID' 'Empirin' Compound
'EMPIRAL'
'Empirin' Compound with Codeine Phosphate, No. 1
'Empirin' Compound with Codeine Phosphate, No. 3
'Empirin' Compound with Codeine Phosphate, No. 4
'CODEMPIRAL' No. 2
'CODEMPIRAL' No. 3
HEADACHE
BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New
GRIP-TIGHT CAP
for Children's
Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.


for
the acute
asthmatic
attack elixir
synophylate®
(Theophylline Sodium Glycinate)
RAPID ORAL CONTROL
WITHOUT G.I. IRRITATION
ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.
Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]
the most potent theophylline elixir available... may avoid need for I.V. injection
1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.
Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P.
Supplied: Bottles of 1 pint and 1 gallon.
Literature on request.
...particularly useful for children
Products Born of Continuous Research
THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

ChallengesDoc tors to Meet Public's Need, And to Sell

By Claude Robinson, Ph.D.
Chairman of the Board, Opinion Research Corporation
Princeton, N. J.

(Because of the importance of this subject, The Council of MSMS directed that excerpts of Doctor Robinson's remarks be reprinted. The talk, delivered in Chicago, August 20, 1959, has been condensed by R. W. Teed, M.D., chairman of the MSMS Public Relations Committee.)

For the past 20 years I have been in the front line trenches in this battle of socialization of our national life. I have served on many fronts and have had the opportunity of participating in a great number of industrial and public relations campaigns. At the same time, I have been engaged in scores of campaigns to merchandise economic goods and services.

This has been something of a unique professional experience, and out of it I have formulated an operative theory which I believe is both practical and effective in our struggle today.

* * *

I HAVE COME to the conclusion that if we will define our struggle against socialism basically as a merchandising problem we will be dealing not only realistically with it but also we will have some very extensive guide lines in the field of merchandising to direct us.

In any merchandising situation you always have the problem of the product and the sale of the product. Any successful merchandiser would testify that it is necessary first to make a good product, with features, style, quality and various other attributes that the consumer wants and will pay for. Also the product must be priced attractively.

However, a good product alone is not enough in itself. Good products must be sold; they don't sell themselves.

The key to successful selling boils down to two fundamentals: First, we study the needs and interests of our prospect, and then we undertake to show him how our merchandise will satisfy those needs better than the merchandise of the competition.

It may seem a far cry when we talk about merchandising as applied to the problem of defeating the advance of collectivism, but the truth is that the only real difference is content.

* * *

YOU IN ORGANIZED medicine feel that you have a good product to sell. Your product is medical leadership and also a set of institutional relationships governing the practice of medicine and the relationships between doctor and patient.

You believe in this product, and you can point to the spectacular control of disease as achieved by medicine, and the rising curve of

longevity as an indication of the success of this medical leadership. You want people to have confidence in this medical leadership, and also you want them to believe in and support your point of view on how this great practice of medicine and the betterment of health should be organized.

In recent years competing suppliers have come into this medical marketplace, offering a bill of goods that has some attraction for the customer. These competing bills of goods are an anathema to medical men.

The principal competitor, of course, is government —or, more accurately, certain types of reformers who want government to organize medical care. The government would pay for medical care, and in the name of finance, control doctors.

When you try to organize a system of medical practice, under one aegis you begin to control that practice. Eventually the whole medical book will be controlled by this route—the training of doctors, the doctor-patient relationship, and even, I am sure, medical diagnosis and procedure. For once the state starts on an operation of this kind there is no stopping short of complete control.

One other competitor that has come into the marketplace recently is the labor union. The labor union is interested in collecting dues. It feels that it has the need to perform services for its members, particularly protective services.

People are concerned about job security and about health and the economic causes of illness. So, the union has a natural field in the area of health. If the union members look to the union for welfare as well as wages, quite obviously the union can better control its members.

* * *

THIS AMERICAN SOCIETY is a society of mobility. Do you know that 25 per cent of the people change their residence each year? We are intellectually mobile, as indicated by the rise of college graduates. We are ethnically mobile by the fact that the Antonellis marry the Jacowskis. We are socially mobile, as indicated by the fact that we move to suburbs. We are occupationally mobile, as indicated by the turnover of personnel. Is it any wonder in this wholly mobile society of ours that the status quo is yielding everywhere to new ideas and new ways of doing things?

There are two or three ways to react to this condition. One is to anticipate change, enhance it and lead it. Another is to kind of tag along, maybe remonstrating along the way. Yet another is to resist, to fight it off, to say it isn't so.

I think it must be agreed that the medical profession is remarkable in its ability to accept, anticipate and promote technological change.

In that area this profession is superb. On the other hand, we have to agree that we have been somewhat slower in our adaptation and anticipation of social change and meeting in this field the institutional challenges forced on us by our competitors.

The case of medical insurance is perhaps one good example of where we finally came around to the idea that perhaps we can live with it. However, I don't think the history of medical insurance would say that this profession has been altogether in the lead.

There are many problems connected with medical insurance that Blue Shield and Blue Cross and other techniques for insuring medical care provide. But nevertheless the fact is that the people wanted some better way of paying for medical care. They wanted an institutional change. The fact that they have gotten it in a very dramatic way—when you look at the growth of insurance systems—is very remarkable indeed.

Going on for just a moment, the competition from the socialists today is not frontal. The new attack is a creeping attack. It is on a specific objective: A new TVA; attempts to regulate—Forand bills. The strategy is to declare for the good life, to get on the side of the angels, to help the common man, protect against disaster, have better schools and health—in other words, big brother will take care of you.

Incidentally, government has some very good symbols—humanity, protection for the underdog, and so on, and some very bad symbols such as waste, red tape, politics and graft, and it particularly has a little thing called higher taxes which somehow people don't seem to like.

The medical profession has enormous prestige, tremendous and profound respect for the dedication of men, for their medical competence, for their past accomplishments, and for their hard work.

However, there are some clearly marked complaints.

There is the complaint of dollar-mindedness. Somehow this "lucre" point of view, as against service, influences the thinking of some people.

Also, interestingly enough, you have a thing like waiting. People go to a waiting room and wait and wait and wait, and they interpret this as an assault on their ego.

We also know there is a communications problem

(Continued on Page 398)

Schering

Trilafon® perphenazine for the anxiety in the person overwhelmed by family illness... selective anxiety relief with minimal drowsiness or dulling

9-419



HAY FEVER · ASTHMA

How to restore your patient's allergic balance the "classic" way . . . use specific desensitization for

LASTING IMMUNITY

For General Medicine, Internal Medicine, Eye, Ear, Nose, Throat, Pediatrics and Dermatology



ALLERGIC BALANCE is determined by skin testing. Diagnostic Sets $2 and up. Skin test your patients quickly and safely in your own office.



LASTING IMMUNITY is achieved by desensitization, economically, with IMMUNOREX, the "classic" treatment (contains only the specific irritants to which your patient reacts).

BARRY

since 1928

Send TODAY for a complete catalogue and, if you wish, a Physician's Handbook and Manual for Nurse Assistant; to Barry's Allergy Division.

Barry Laboratories, Inc. • Detroit 14, Michigan
Manufacturers of Biologicals and Pharmaceuticals

(Continued from Page 396)

of the simple interpretation of the point of view of this profession.

So, there are three or four things that must be basic in our approach:

First, we must improve the service—cut down on complaints.

Second, we must continue to study the medical market and the needs and desires of the customers, and develop our answer to beat the competition.

There are two prime movers in this effort. The first must be the society, the national society, the state and local societies, to study the market, that set up programs, that conduct the over-all sales effort that an individual sales practitioner can't do. However, I don't believe there can ever be any compromise with the fact that good public relations begin at home.

Therefore. the doctor must be made to realize the effect of his behavior on the standing of the profession. He must have a point of view on the organization of medicine. He ought to be able to get up in the First Baptist Church or the high school civics class and discuss the question of the organization of medicine in terms of the good of the community. Finally, he also must be willing to work at it.

Doctors are a very powerful group, and they don't realize their strength if they organize. In order to exercise, fulfill and articulate this power, they first must meet the public's need, and then they have to do a lot of selling.

If doctors really like the idea of practicing in an area of freedom, they have got to assume some responsibility for preserving it.

"Good public relations is good performance which is understood and appreciated."—*California Medical Association Newsletter*, Vol. 4, No. 11.

* * *

"All of us who deal with communications must conceive of our task in the broadest possible terms of winning informed public support for our organization's objectives, policies, and practices. All that we do must contribute toward that goal. It makes no difference whether we are organizing a press conference to announce a new product, conducting the local press on a plant tour, or releasing the text of an Executive Office speech; we must always look beyond the immediate task to the broader objective."—S. C. Van Voorhis, General Electric, in speech before San Francisco Bay Area Chapter of Public Relations Society of America.

* * *

"Better health for all depends in large part on a well-informed public. Participation by physicians in enlightening the general public in matters of health is today an important part of the practice of medicine."—*Therapeutic Notes*, Vol. 66, No. 11.

reaches all nasal and paranasal membranes *systemically*[1]



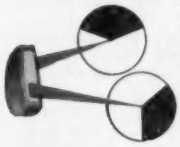
Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic*[2,3] *is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

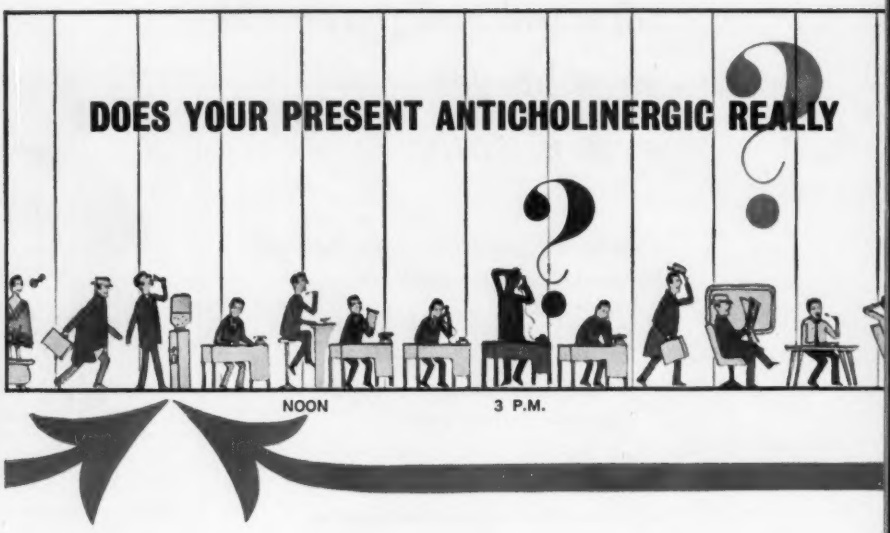
1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

COMPARE THE DATA ON ENARAX . . . the new combination of an **inherently** long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

OBSERVE THE OXYPHENCYCLIMINE REPORTS . . .

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

Kemp: ". . . for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action . . . may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."[2]

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

LOOK AT THE RESULTS WITH ENARAX[4,5]:

Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that **does.**

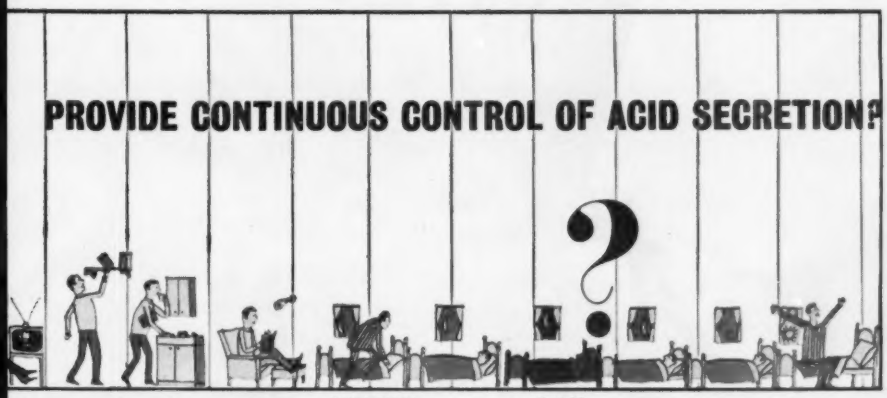
ENARAX®

(oxyphencyclimine plus ATARAX®)

A SENTRY FOR THE G.I. TRACT

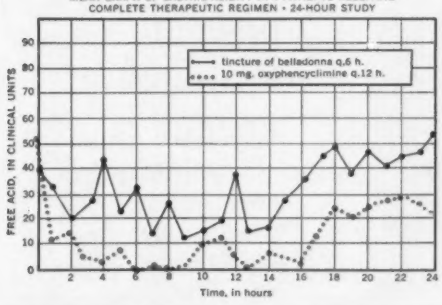
Say you saw it in the Journal of the Michigan State Medical Society

PROVIDE CONTINUOUS CONTROL OF ACID SECRETION?



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[2]

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth. . . ."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

ROERIG

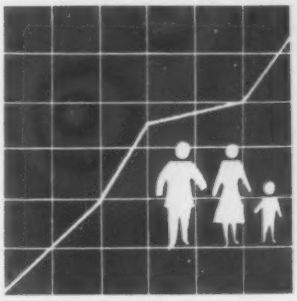
New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Say you saw it in the Journal of the Michigan State Medical Society

M.D. Gets Smaller Share of Medical Care Dollar



As contrasted with twenty years ago, the American doctor of medicine is getting a smaller share of the medical care dollar today.

In 1938, physicians received 31 cents of the medical care dollar, the physician's share in 1958 was 24 cents—or 22.6 per cent less than twenty years ago.

This fact was revealed by the Economic Research Department of the American Medical Association, based on U. S. Department of Commerce data.

The breakdown of figures was based on a total of $16.4 billion spent for medical care in 1958—an average of $95 a person. This represents 5.6 per cent of the $293 billion spent by Americans during the year for all goods and services. The percentage of 1958 expenditures for medical care compares with 5.8 per cent for recreation and 5.3 per cent paid out for tobacco and alcoholic beverages.

Of total consumer expenditures for medical care in 1958, hospitals claimed $4.3 billion, physicians $3.9 billion, drugs $3.3 billion, dentists $1.7 billion, health insurance $1.4 billion, and ophthalmic products and orthopedic supplies $1.1 billion.

The remaining $769 million went for all "other medical costs," including osteopathic services, private duty nurses, chiropractors, chiropodists, and other miscellaneous curative and healing services.

Items showing a proportionate increase include hospitals, which received 17 cents of the dollar in 1938 and 26 cents in 1958—a jump of 52.9 per cent. Hospitals attribute this rise to the expansion of hospital services and their greater utilization which has increased the number and variety of skilled personnel required.

"While more Americans are budgeting more of their income for medical care, and more emphasis is being placed on planning against future illness, the physician is receiving a smaller portion of the total money spent for medical care," points out the AMA.

In addition to the amount which physicians and dentists received as their share of the medical cost dollar, 22 cents went for drugs in 1938, but the figure dropped 9.1 per cent in 1958 to 20 cents. Purchases of appliances took another 7 cents of the 1958 dollar, while items in the "all other" categories claimed the remaining 5 cents.

Care for Aged Challenge Met by Blue Shield Plans

The nationwide Blue Shield Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution—passed in December 1958, calling for the development of medical care coverage for the aged by voluntary means reports John W. Castellucci, executive vice-president of the National Association of Blue Shield Plans.

About 98 per cent of the total United States Blue Shield enrollment is in areas where special aged programs are already being offered or are in stages of development, all within one year following passage of the AMA resolution.

"Only eight of the sixty-seven Blue Shield Plans located in the United States, with only two per cent of total Blue Shield membership, have no programs for senior citizens in the works at the present time," he noted.

Mr. Castellucci said that the remaining fifty-nine Plans either have special aged programs already being offered in their areas, or have programs in various stages of development. Specifically, the study conducted by the national Blue Shield association showed that thirty-two of the Plans, representing more than 50 per cent of total enrollment, have made available nongroup programs for persons over the age of sixty-five.

Mr. Castellucci indicated that in the development of programs for senior citizens, the Plans have followed three general lines of approach: (1) Developed new programs designed specifically for persons over sixty-five; (2) effected modifications in existing programs to accommodate enrollees over sixty-five; (3) eliminated age limits on existing nongroup programs offered to the general public who are not eligible to join through their place of employment.

"In offering these programs Blue Shield, of course, is fully cognizant of the splendid co-operation offered by sponsoring medical societies without whose efforts such significant progress could not have possibly been recorded in twelve short months," Mr. Castellucci concluded.

Urges Social Security Study

The broad social and economic impact of social security benefits and the method of financing them should be studied by the best qualified individuals in the United States before any further increases are considered, contends Ray M. Peterson of New York, vice-president and associate actuary of the Equitable Life Assurance Society.

"The system needs study in relation to capital needs, the capacity to save, demands upon our production and the role of private retirement plans," Mr. Peterson says. At the same time, he expressed concern over "a lack of legitimate and healthy anxiety as to the future successful operation of our social security financing method."

"How will the margin for personal savings be affected by compulsory social security contributions which are scheduled to increase by 80 per cent in ten years?" he asks. "How will the willingness to save, particularly for the purchase of life insurance be affected when the margin for savings is reduced and there is increased reliance on old age and survivor benefits from the Government insurance system?"

Sees '60 Big for Michigan

With the national outlook being one of increasing demand for automobiles and other hard goods by consumers and growing demand for industrial durable goods by businesses, it seems obvious that 1960 should be a year of expanding income, employment, production, and consumption in Michigan.

Business Week recently made a forecast of personal income by states for 1960. Its prediction was that total personal income in Michigan would increase by 8.2 per cent compared to a national gain of 6.4 per cent, and that per capita income in Michigan would increase by 6.3 per cent compared to a gain of 4.6 per cent for the nation.

If employment in 1960 increases at even half the rate predicted for personal income, unemployment should be reduced to a level about equal to that in 1956. It is even quite possible that the 1960 employment picture will be the best since 1955, the all-time bonanza year for the automobile industry.

—*The Michigan Economic Record*, Michigan State University College of Business and Public Service, January, 1960.

Medicine Costs Top Health Expenses

Bills for medicine and appliances are greater than doctor bills for Americans. The breakdown of the nation's health bills for 1958 compiled by the Social Security administration shows this:

Hospital bills amounted to 5.1 billion dollars for all Americans. Of this amount, 2.6 billion, more than half, was paid by insurance.

Doctor bills amounted to just under 4.3 billion dollars. Of this total, about 1.3 billion was paid by insurance.

Bills for medicine and appliances, such as eye glasses came to nearly 4.4 billion dollars exceeding doctor bills for the first time in history. Only a small fraction of this outlay was paid by insurance.

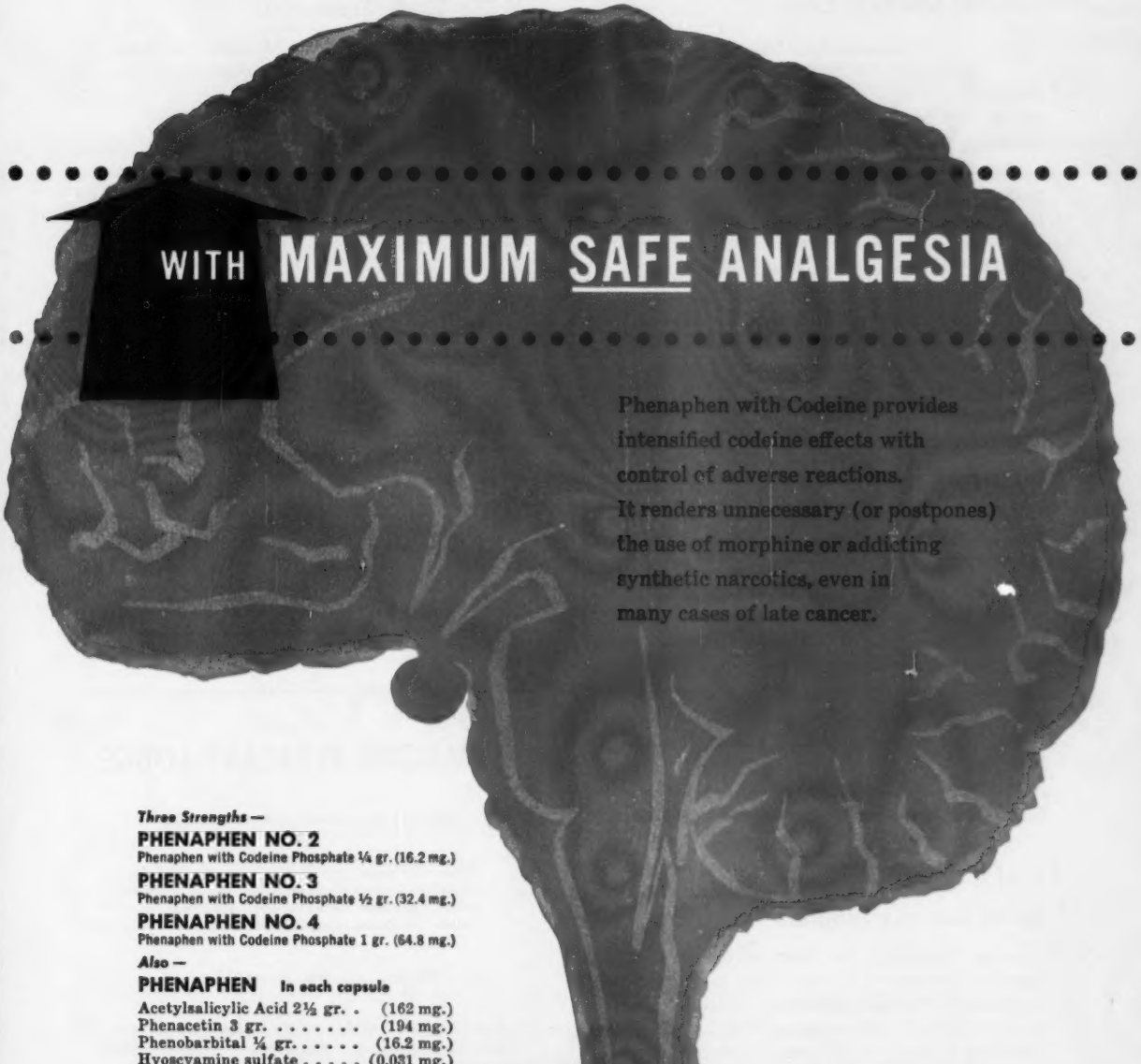
—*U.S. News and World Report*, Jan. 4, 1960

Rates Teacher Shortage Critical

We are rightly concerned that the shortage of teachers on medical faculties is fast developing to a crisis. The Council on Medical Education has re-

(Continued on Page 406)

Raise the Pain Threshold



WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Teacher Shortage Critical

(Continued from Page 404)

ported that in 1957, there were 331 unfilled positions on the faculties of our medical schools. Last year, vacancies climbed to 619.

Not only does the crisis in medical education imperil the training of future physicians, but it may very well act as a brake on the advance of medical knowledge itself. Given these conditions, industry support of medical education is as much a necessity as it is a philanthropy.

From talk by John E. McKeen, President, Charles Pfizer & Company, before the Research and Development Section of the Pharmaceutical Manufacturers Association, White Sulphur Springs, W. Va., November 4, 1959.

Sixty-Four Per Cent to Specialize

Sixty-four per cent of 4,377 male graduates and 71% of 228 women graduates of U.S. medical schools in 1959 planned to practice a specialty.

Of the remaining male graduates, 27% favored general practice, 7% planned full-time teaching or research, and 2% were undecided. Among women, the percentages were, respectively, 16, 11 and 2.

AAMC Study: The figures are included in a study of medical education conducted by the Association of American Medical Colleges, Evanston, Illinois, under Dr. Lee Powers' direction.

The study examined aspects of medical education from construction costs to income and expenditures.

C of C Opposes Expansion of Social Security Program

Strong opposition has been voiced by the Los Angeles Chamber of Commerce to proposed federal legislation that would expand the social security program to include government-controlled medical care, according to Southern California Business.

President J. E. Fishburn, Jr., declared that under the Forand bill (HR 4700), a government-controlled health plan would bring to a halt the "excellent progress of private, voluntary efforts to provide adequate health insurance coverage to those needing it in all brackets. It would provide another setback to the ability of citizens to take care of their own problems."

He said the Chamber believes it would be highly undesirable from a fiscal standpoint to make liberalizing changes in the social security system based on the present faulty foundation.

M.D.'s Study Economics

A group of Springfield, Missouri, physicians has been meeting at 7 a.m. once a week to learn the practical side of politics. Their aim is to become effective citizens taking part in government.

Their nine-week Action Course in Practical Politics was prepared by the U.S. Chamber of Commerce. Similar courses are being conducted in many U.S. cities by industries, chamber of commerce, labor unions, and other groups.

* * *

Predicts Prepaid Growth

Prepaid health insurance will pay two-thirds of the medical bills within the next five to ten years, predicted Jerome Pollack, veteran health and welfare negotiator for the United Auto Workers, AFL-CIO.

He spoke at the recent fifteenth annual meeting of the Western Conference of Prepaid Medical Service Plans held in Honolulu, Hawaii.

Pollack claimed there are three pressing needs in the insurance field:

—More comprehensive coverage.
—More lay representation on prepayment boards.
—More economic controls by doctors.

—*AMA News*, December 28, 1959

SAMMOND PLEASANT LODGE

Offers to the elderly and chronically ill

Peace and quiet. Freedom of a large and richly furnished home and acres of lawns and wooded rolling grounds, scientifically prepared tasty meals, congenial companionship. A real

"Home away from Home"

Approved by the American Medical Association and Michigan State Department of Social Welfare—Highly recommended by members of the Medical Profession who have had patients at the Lodge.

For further information write to:

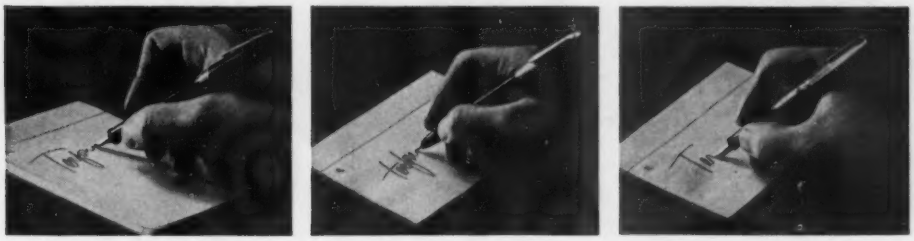
SAMMOND PLEASANT LODGE

124 West Gates Street

Romeo, Michigan



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

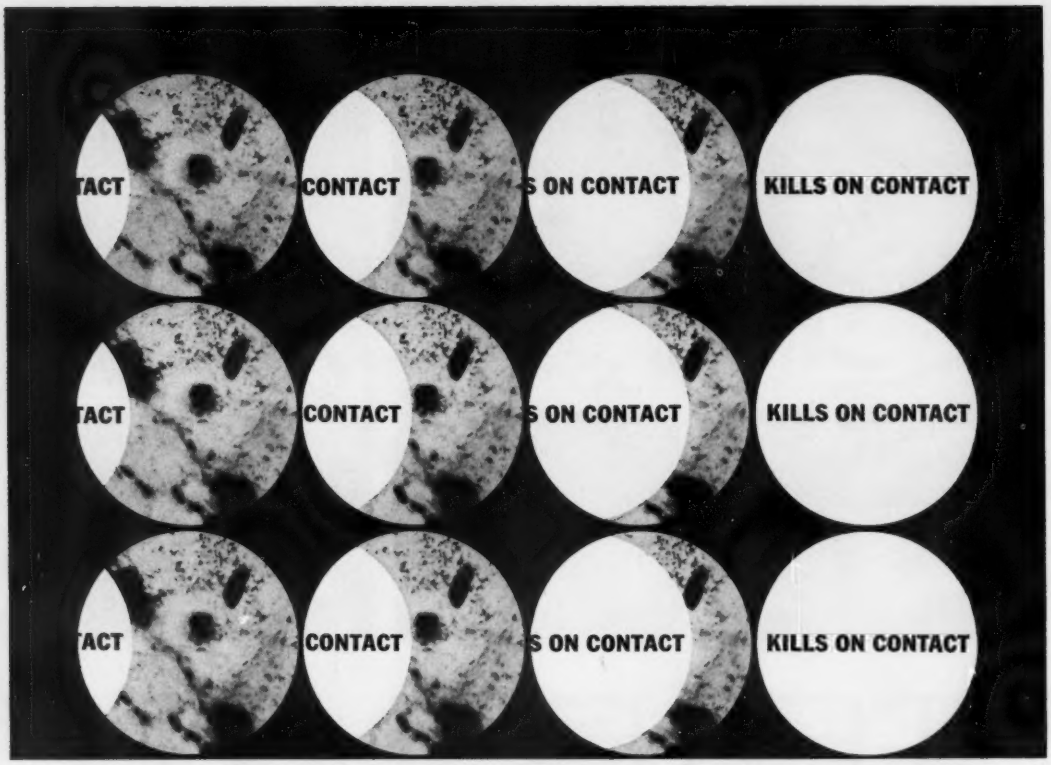
Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

. specificity for a wide range of organisms . superinfection rarely encountered . soluble in urine through entire physiologic pH range . minimal disturbance of intestinal flora . excellent diffusion throughout tissues . readily crosses blood-brain barrier . sustained therapeutic blood levels . extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

SQUIBB *Squibb Quality—the Priceless Ingredient*

"TERFONYL"® IS A SQUIBB TRADEMARK



KILLS ON CONTACT[1-6] Trichomonads, Monilia and Other Organisms Responsible for Non-Specific Infections in The Vaginal Tract

BETADINE™
(ACTIVE INGREDIENT: POVIDONE IODINE*)
DOUCHE

DESTROYS all vaginal pathogens on contact (even in presence of blood, pus, vaginal secretions). **PENETRATES** into vaginal rugae. **STOPS** discharge and pruritus, reduces malodor. **CLEARS** the vaginal tract without irritation or sensitization . . . has been used with considerable success even in difficult and refractory cases.[6]

BETADINE™ VAGINAL GEL should be applied where more prolonged contact is required or when a douche may be inconvenient or contraindicated. **SUPPLIED:** Betadine Douche—8 fl. oz. bottle. Betadine Vaginal Gel—3 oz. tube with applicator.

REFERENCES: 1. Gershenfeld, L.: Am. J. Surg. 94:938, 1957. 2. Stone, J. D., and Burnet, F. M.: Australian J. Exper. Biol. & Med. Sc. 23:205, 1945. 3. Reddish, G. F.: Antiseptics, Disinfectants, Fungicides and Chemical and Physical Sterilization, Lea & Febiger, Philadelphia, 1954, pp. 171-211. 4. Chang, S. L., and Morris, J. C.: Engineering Chem. 45:1009, 1953. 5. Shelanski, H. A., and Shelanski, M. V.: Polyvinylpyrrolidone-Iodine Studies Through 1951, G. A. & F. Corp. 6. Christhilf, S. M., Jr.: Personal Communication.

TAILBY-NASON COMPANY, INC. DOVER, DELAWARE
established in 1905

*PAT. 2,739,922 G. A. & F. CORP.

SPEED



DURATION



IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN® Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available—for greater flexibility in dosage—PERCODAN®-DEMI. The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

U.S. Pat. 2,628,185



In her book, the lasting relief from colds puts NTZ Nasal Spray in a class by itself.

NTZ® **NASAL SPRAY**

20 cc. spray bottles;
also 1 oz. bottles with dropper

Neo-Synephrine® HCl, 0.5%
—unexcelled decongestant—

Thenfadil® HCl, 0.1%
—topical antihistaminic—

Zephiran® Cl, 1:5000
—antibacterial spreading agent—

Winthrop LABORATORIES
New York 18, N. Y.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Potentiated Relief for Colds...Sinusitis...Hay Fever

Say you saw it in the Journal of the Michigan State Medical Society

51 to 49...it's a boy!





94 to 6 BONADOXIN® stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male.[1] But when she mentions morning sickness, your course is clear: BONADOXIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%.[2] More than 60 million of these tiny tablets have been taken. The formula: 25 mg. Meclizine HCl (for antinauseant action) and 50 mg. Pyridoxine HCl (for metabolic replacement). Just one tablet the night before is usually enough.

BONADOXIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

Roerig

New York 17, New York
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609
in the Therapy of

ACUTE PHARYNGITIS, ESPECIALLY WITH LYMPHADENITIS

Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible[a] to Tetracycline **(TETREX)[b]**

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

The semisynthetic tetracyclines have been in constant use since they were introduced in 1952. They have been proved clinically and have established themselves as safe, effective, and valuable antibiotic agents. But the final decision, the choice of agent, and the control of therapy must remain where it has always been, in the hands of the individual physician.

References: 1. Zinsser, H.: A Textbook of Bacteriology. 11th edition, New York, Appleton-Century-Crofts, 1957, p. 409. 2. Welch, H.: Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (December) 1957.

BRISTOL LABORATORIES
Division of Bristol-Myers Company
SYRACUSE, NEW YORK

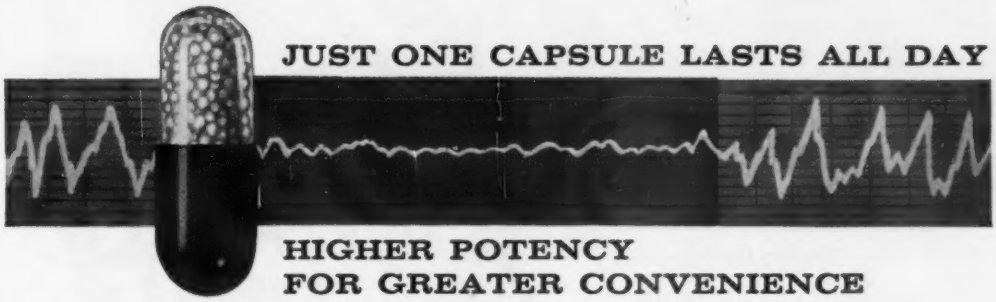
Say you saw it in the Journal of the Michigan State Medical Society

NEW AND EXCLUSIVE

FOR SUSTAINED TRANQUILIZATION

MILTOWN® (*meprobamate*) now available
in 400 mg. continuous release capsules as

Meprospan®-400



JUST ONE CAPSULE LASTS ALL DAY

**HIGHER POTENCY
FOR GREATER CONVENIENCE**

- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast, one capsule with evening meal

Available: *Meprospan-400*, each blue capsule contains 400 mg. Miltown (meprobamate)
Meprospan-200, each yellow capsule contains 200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

WALLACE LABORATORIES, *New Brunswick, N. J.*

CME-0426

versatile dermatotherapy



for JUNIOR and SENIOR citizens



DESITIN®
OINTMENT
rich in **cod liver oil**



in pediatrics

Desitin Ointment is unequalled in preventing and clearing up **diaper rash,** excoriation, irritation, chafing.

in geriatrics

an incomparable protectant and healing agent against excoriation due to incontinence; senile pruritus, excessive skin dryness.

Write for **samples** and literature

DESITIN CHEMICAL COMPANY
812 Branch Ave., Providence 4, R. I.

Say you saw it in the Journal of the Michigan State Medical Society

announcing a major event in anticoagulant therapy...

Schering

Certified—before introduction—by 5 years of clinical experience and published reports in the U.S.A., Canada and Great Britain.

Miradon®

anisindione

new oral prothrombin depressant

control at every stage of anticoagulant therapy **rapidity** of induction and recovery time **predictability** of initial and maintenance dosages **stability** of therapeutic prothrombin levels during maintenance therapy **reversibility** of anticoagulant effect with vitamin K_1 preparations... rapid return to therapeutic levels on remedication

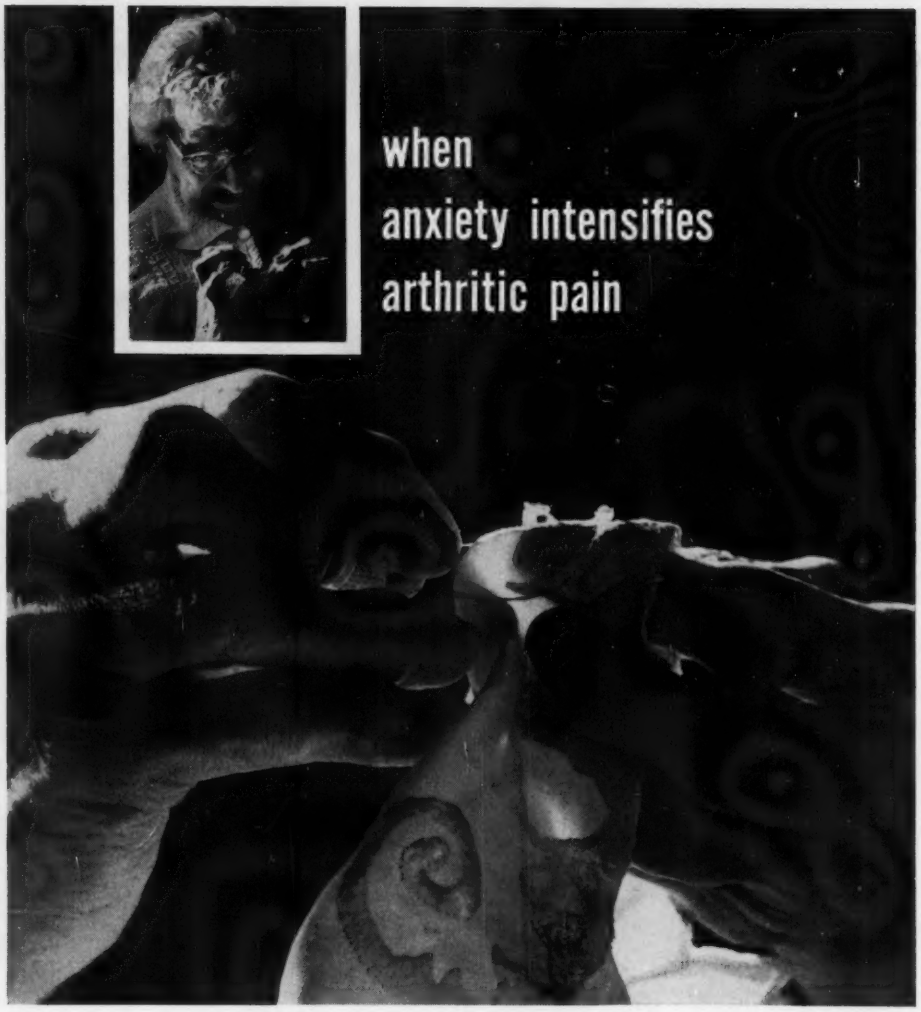
Well tolerated and relatively nontoxic no nausea and vomiting, proteinuria, agranulocytosis or leukopenia yet observed —chromaturia infrequent and transient.

Single daily dose convenience

Packaging— MIRADON Tablets, 50 mg., bottle of 100.

For complete information on indications, dosage, precautions, and contraindications consult the Schering Statement of Directions.

5-415



. . . DARVO-TRAN™ relieves pain more effectively than the analgesic components alone

Effective analgesia *plus* safe relief of mild anxiety helps combat the pain-anxiety spiral. In Darvo-Tran, the tranquilizing properties of Ultran® are added to the established analgesic effects of Darvon® and the anti-inflammatory benefits of A.S.A.®. Clinical and pharmacologic studies have shown that when pain is accompanied by anxiety, the addition of Ultran *enhances* and *prolongs* the analgesic effects of Darvon.

Lilly

Each Pulvule® Darvo-Tran provides:

Darvon	32 mg.	TO RAISE PAIN THRESHOLD
A.S.A.	325 mg.	TO REDUCE INFLAMMATION
Ultran	150 mg.	TO RELIEVE ANXIETY

Usual Dosage:
1 or 2 Pulvules three or four times daily.

Darvo-Tran™ (dextro propoxyphene and acetylsalicylic acid with phenaglycodol, Lilly)
Ultran® (phenaglycodol, Lilly)
Darvon® (dextro propoxyphene hydrochloride, Lilly)
A.S.A.® (acetylsalicylic acid, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

020407

Say you saw it in the Journal of the Michigan State Medical Society

Antibiotics—Their Use and Abuse

Perrin H. Long, M.D., F.R.C.P.
Brooklyn, New York



IF THE EXPERIENCE of the reader has been anything like that of the author, you have been under constant bombardment by mail, and by pharmaceutical manufacturers' representatives relative to the indications for use of, the pharmacology of, and the clinical results with, the various brands of antibiotics.

However, there exists, a relatively new antibiotic, the generic name of which is kanamycin (Kantrex®), which has demonstrated its value in the treatment of staphylococcal infections, of certain infections produced by members of the Salmonella group, and of infections produced by strains of *Proteus mirabilis*. This compound is not well absorbed from the gastrointestinal tract and hence has to be given by the intramuscular route. Possibly, strains of staphylococci may become resistant to this antibiotic in the future. The fact remains, however, that at the present time, the chances seem to be favorable that kanamycin will be more likely than other varieties of antibacterial agents to produce the desired therapeutic effects in infections produced by "resistant" strains of staphylococci. In view of the serious problem created by staphylococcal infections today, this is a matter of considerable importance.

When one considers the abuses of antibiotics, one can say without fear of contradiction, that the misuse of penicillin by physicians produces one of the major problems in iatrogenic diseases today. In addition to the increasing number of penicillin reactions which are occurring following the careless and thoughtless use of penicillin for the treatment or prophylaxis of infections (in which this antibiotic has been repeatedly demonstrated to be of no value), more than 100 individuals will die this year of anaphylactic reactions following the administration of penicillin. *As far as I am concerned, I can see little or no excuse for most of these deaths.*

Because of the increasing frequency of serious reactions, or deaths, from the administration of penicillin, I would recommend most strongly that physicians adopt the following precautions to protect their patients from reactions and themselves from punitive actions.

Presented at the 93rd Annual Session of the Michigan State Medical Society, Detroit, October 3, 1958.

From the Departments of Medicine, The Kings County Medical Center, and The College of Medicine, State University of New York, New York, N. Y.

1. Do not administer penicillin to individuals who have viral infections of the respiratory tract, that is the common cold, influenza, grippe, viral sore throats, viral pneumonia, et cetera.
2. Be very cautious in administering penicillin to patients who have, or have had asthma, hay fever, allergic eczema, and other allergic phenomena.
3. Before administering penicillin in any form, ask the patient if he or she has ever had penicillin, and if so, whether a reaction to penicillin occurred. If the answer is "yes," it is better to administer another antibiotic.
4. If there is any question about administering penicillin, then it is better not to give it.

If these injunctions were followed, it is likely that deaths from reactions to penicillin would be more than halved and the number of non-fatal reactions would be decreased.

I don't know how many of the members of the audience realize it, but as a result of country-wide surveys and tests conducted by the Food and Drug Administration, it appears that from 5 to 10 per cent of the milk sold on any day in this country, contains detectable amounts of penicillin. This occurs because it is the custom of dairymen to treat mastitis in cows by the injection of penicillin ointment into the infected quarters of the cow's udder, and then when the milk appears "clear" it is marketed, despite the fact that it contains penicillin. Just what role the ingestion of milk containing penicillin plays in sensitizing the population of this country to penicillin, is unknown at the present time. However, it would appear to be a potential hazard, and milk containing penicillin has been known to produce serious reactions in individuals who were highly sensitive to this antibiotic.

The tetracyclines, erythromycin, and carbomycin have produced very little in the way of toxic reactions. Anaphylactic episodes have not been reported, and instances of dermatitis have really been very rare. While harm to the patient from a superinfection with molds or bacteria has occurred when a member of the above-named group of antibiotics has been used, such an occurrence can not be classed as a toxic reaction, but rather one due to the anti-bacterial effects of the antibiotic.

Chlortetracycline (Aureomycin) is being used to protect dressed poultry from deterioration. This process presents no health problem because chlortetracycline is very sensitive to heat and is destroyed in the cooking of the poultry. There is, however, the outside chance that it might produce a contact dermatitis in handlers of dressed poultry.

It is a good thing for the physician to remember that Polymyxin B, Bacitracin, or Neomycin may produce renal damage and because of this, the urine of patients who are receiving one of these antibiotics should be carefully checked each day. The injunctions relative to the proper and careful use of chloramphenicol still hold. It is a valuable antibiotic which should be used when it is the antibacterial agent of choice. Streptomycin and di-hydrostreptomycin are still producing reactions of sensitivity, deafness, and vertigo. Serious damage can generally be avoided if care is taken to check frequently for the early occurrence of damage to the eighth nerve.

In conclusion, I would like to make a plea for tightening up on aseptic procedures in operating and delivery rooms, and in hospital wards. The efficacy of the sulfonamides and antibiotics in the treatment of many infections lulled the medical profession into a state of euphoria, characterized often by a flagrant disregard for the principles of aseptic technique. The net result has been an increasing number of intra-hospital infections. *These can be stopped and must be stopped.*

451 Clarkson Avenue
Brooklyn 3, New York



THE AUTHOR
Perrin H. Long, M.D.

Reports on Lung Cancer Study

Community air pollution has no known effect on lung cancer, says the director of The University of Michigan's Institute of Industrial Health. Seward Miller, M.D., declares: "There is as yet no substantial statistical, epidemiological or research evidence that breathing polluted air in our communities causes lung cancer."

Studies have identified one substance in motor vehicle exhausts called "benzpyrene." Although it can produce skin cancer in mice, high concentrations of benzpyrene have failed to produce lung cancer even during extended periods of exposure, he says. Cites two major problems in air pollution: the "acute" form of pollution, which produced deadly blankets of smog at Denora and London, and the "chronic" form which most communities experience throughout the year.

"We may never experience another episode of acute community air pollution serious enough to cause severe illness and death," Doctor Miller said. "Today our concern centers on the adverse effects of breathing slightly polluted air over a long period of years."

Seminar on Graduate Medical Education

Welcome

Milton R. Weed, M.D.
President, Wayne County Medical Society
Detroit, Michigan

ON BEHALF of the Wayne County Medical Society, it is my privilege to welcome you to this Seminar on Graduate Medical Education sponsored by the Greater Detroit Hospital Association. It is particularly fitting that this meeting be held here, for during the past 110 years this Society has played a leading role in medical education in this community. It has contributed to postgraduate medical education in time, treasure, sweat and sometimes in hot air.

During five score and ten years, medical education has changed profoundly. During the past twenty years, we have witnessed social and economic changes which have created greater problems than we have ever known. Our problems today are the reason for this conference. In these twenty years, we have seen change from a surplus to a shortage of interns and residents available for training; with prepaid medical insurance we have watched the gradual disappearance of charity patients who were used for training purposes and increase in private patients; and, we have felt the tightening grip of the predication device and have witnessed the confused emergence of directors of medical education. Some administrators seemingly tolerate these individuals because they set up paper programs which are acceptable to the accrediting bodies, thereby making available a cheap supply of labor. We have also seen the AMA House of Delegates establish the popularity of the training program as one of the criteria for its approval. In general, despite some blundering, there has been some progress, and meetings of this type should go far in resolving current problems.

Seminar held in the Wayne County Medical Society Headquarters in Detroit, under auspices of the Greater Detroit Area Hospital Council, May 13, 1959.

Introduction

H. C. Saltzstein, M.D.
Harper Hospital
Detroit, Michigan

THIS MEETING is not a happenstance. In April, 1958, a meeting was held under the aegis of the Pennsylvania State Medical Society to discuss internships and attendant problems. A note in its medical journal said it was the first meeting to discuss these problems in sixty years. As the story goes, one hospital in Pittsburgh offered a year's membership in a country club to attract interns. I have heard that this has been done elsewhere.

In thinking over these problems, we thought there might be many mutual interests in these changing situations and possibly cogent reasons for mutual cooperation in education programs. As Dr. Weed mentioned, medical education today is totally changed.

Osler is dead, as is Will Mayo. The day of great personages in medicine is gone. We are subject to many forms of pressure from society in medical education. Population shifts to the suburbs, Blue Cross, married house staff—all have wrought great changes.

We took the idea to Mr. Cousin, Executive Director of the Greater Detroit Area Hospital Council. To his inquiry submitted to all member hospitals, thirty-seven replied that they were interested in a meeting to discuss these problems. A small committee representing Grace (Dr. George McBryan), Harper (Dr. Harry C. Saltzstein), Receiving (Dr. George D. Clifford) and Henry Ford (Dr. Ted Howell) Hospitals in Detroit; University of Michigan Hospital in Ann Arbor (Drs. Harry Towsley and Roger Nelson); and the Hospital Council (Mr. Jacques Cousin) met several times. Then, a questionnaire was submitted to the hospitals asking which topics would be of greatest interest. From the replies the agenda for this meeting was developed.

The Internship

Effects of Current Trends in Graduate Medical Education

John C. Nunemaker, M.D.
Associate Secretary Council on Medical Education and Hospitals American Medical Association
Chicago, Illinois

Current Trends in Medical Education

A BASIC point of reference is the Report of the Advisory Committee on Internships to the Council which was published in THE JOURNAL February 2, 1953. It is not surprising that Dr. Leonard, who is here today, was a member of that committee. This committee was chaired by Dr. Victor Johnson of the Mayo Foundation. Though published in 1953, every word is as current today as it was then and deserves very careful reading. As a result of this report, the *Essentials of an Approved Internship* was rewritten and some requirements were changed. I wish to mention eight items briefly.

1. *The Intern Shortage.*—I have before me the Directory of Approved Internships and Residencies published October 4, 1958, in THE JOURNAL, and an editorial from that issue entitled "No Single Panacea for the Internship" by Dr. Leland McKittrick, now chairman of the Council on Medical Education and Hospitals. A few words in this editorial I want to read:

> "Nevertheless these hospitals represent a very small proportion of all the hospitals in this country, and the number seeking interns is increasing. It can be seen, therefore, that the number of students graduating annually is not sufficient to supply interns for all hospitals seeking them, far less to meet the demand if all general hospitals should desire to use them. This, meanwhile, is one of the bases for the claim that there is a dearth of physicians. It can be readily seen, however, that sufficient interns could not be provided for all hospitals even if the annual number of graduates exceeded by several times the normal output for this country. The intern problem must be solved in some other way. Many hospitals, even now, are employing physicians as residents or house officers at increasing salaries or with gradually increasing privileges in the way of practice. Interns, also, should be relieved of much of the work required of them which should be done by orderlies employed for that purpose. History writing and records, which have depended largely on intern services, can be kept up by staff physicians through the use of stenographers. It is certain that the increased demand for interns does not justify either the lowering of educational standards or the multiplication of medical schools."

The striking thing about what I have read is that it was published in 1920, only six years after the AMA began publishing lists of internships. I expect the concern expressed then and today will continue. There is "overage" of approved positions as well as of desire for interns; but, there will always be "shortage" of interns as well as of yachts.

2. *Effect of Congressional Action.*—The United States Information and Educational Exchange Act of 1948 became effective July 1, 1949, and facilitated the

foreign graduate coming to our shores. A new chart is to be published this fall which will show the fantastic postwar growth of graduate training programs. Superimposed on it will be the participation of the foreign graduate. Certainly the foreign graduate is not responsible, but he has been used and abused as a result of the great increase in training programs. It was this Act of 1948 that made it possible for the foreign graduates to come to this country easily.

As far as internships go, of about 5,000 vacancies for interns, 2,000 are filled by foreign graduates. I brought a letter from Dr. Dean Smiley, Executive Director of the Educational Council for Foreign Medical Graduates, with a few of the latest figures on foreign physicians in the United States. There are 7,622 foreign medical graduates with exchange visitor visas working in U. S. hospitals as interns and residents. About 1,000 more serving hospitals have immigrant visas. It appears that at least a third of the foreign trained physicians are coming to this country each year and of 7,622 working in hospitals 1,129 have passed one of three ECFMG examinations and 534 have near passed, receiving temporary certificates good for two years. July 1, 1960, it is expected that all foreign medical school graduates starting to serve as interns or residents in U. S. hospitals will have been certified by the ECFMG or by the State Board of Medical Examiners of the state in which their hospital is located. We are certain that while this is going to upgrade the quality of men coming here from foreign schools, it is very likely to reduce the number available for a time.

3. *Advisory Committee Report on Internships.*—here are some of the items. The future of the internship—is there a place for it? The conclusion was that there certainly is a place for a proper internship. Basic principles of a sound educational program were spelled out for a rotating internship, and I would like to read them:

> "By rotating internship we mean one so planned as to provide: (1) continuity of observation of individual patients, (2) continuity of exposure to individual clinicians selected for their devotion to teaching, (3) clinical responsibilities graduated according to the increasing experience of the intern."

They rewrote the *Essentials*, increasing the hospital requirements to at least 150 beds and 5,000 annual admissions. They discussed the intern-patient ratio and the intern quota and recommended that hospitals be disapproved if they could not obtain two-thirds of their quota two successive years. The House of Delegates would not accept that, but we do have the rule under which a hospital may be disapproved if, for two successive years, it does not obtain a quarter of its quota. This does not mean automatic disapproval. The Council must act on every one and there may be valid reasons why a hospital's quota has not been filled.

Of the essential elements in an intern training program, first is well qualified staff, with ability to teach. The essential nature of formal teaching rounds, scheduled and conducted regularly cannot be overemphasized. It is an absolute requirement to have outpatient department experience either on an intramural or an affiliated basis. Though a hospital has a large and busy emergency room, it is likely not to receive approval for an intern program unless it can provide outpatient department experience with regularly scheduled clinics. Laboratory work by the house staff is emphasized, as well as surgical training in preoperative and postoperative care, not just operating room training "on the end of a hook" which too often is the only surgical training an intern gets. The place of psychiatry is throughout the program and not merely a short assignment in a ward for psychotic patients. The major services are sometimes deficient in beds, frequently in the pediatric service, and therefore affiliated relationships must be developed. The general character of salary and maintenance now paid by all hospitals involved in training programs is also discussed.

The private patient problem is thoroughly discussed. A frequent reason for critical evaluation of a program is failure of a given training program to use private patients. I would like to read again from this report because so many doctors have said they cannot use private patients in training or that their staff won't. "In our opinion, from the internship standpoint it makes no difference whatsoever whether the patients are in rooms with baths or wards, or how the hospital or doctor's bills are paid if all of the following things are met: 1. That the patients on private service are as sick and present the same range of disease as those on public wards and that comparable opportunity for follow-up exists. 2. That the attending staff value breadth of viewpoint that comes from time spent in teaching and do not treat teaching as an unwelcome burden inherent in staff privileges. 3. That the teaching attending staff are sufficiently secure in the private doctor-patient relationship to permit house staff responsibility comparable to public wards and understand in practice the distinction between indoctrination

and true learning. 4. That the same critical standards of diagnosis and treatment apply on private and public ward patients."

4. *The Internship Review Committee* was created in 1954 and its representation was made as broad as possible: First, representatives of the Council itself; second, the Federation of State Medical Boards; third, the American Hospital Association; fourth, the American Academy of General Practice; and fifth, the Association of American Medical Colleges. All these major organizations are concerned with the internship and it is possible not only to review the applications and survey reports submitted by our field staff and to make recommendations for or against approval, but also to recommend to our Council changes in policy or changes in standards. In other words, this committee has a continuing responsibility, as did the Advisory Committee on Internships, against a background of continual review of programs.

5. *The Council Staff Surveying and Evaluating Procedures.*—Many people do not realize that, in addition to myself and two other physicians in our office concerned solely with graduate training programs, we have five full time physicians in the field. Internships have increased since the war only by about 50 per cent—from 8,000 to 12,000. Residencies have increased from 5,000 to over 31,000. This has been fantastic and we are trying to evaluate these programs with much the same machinery we had ten years ago. We must retool if we are going to do this right and our present concern is whether we can attract high quality men to our field staff who are willing to work on a part time basis but who under no conditions would take the traveling job full time. Moreover, a number of review committees in the specialties are considering whether panels of consultants should be nominated who would work quite unrelated to the review committees. They could serve hospitals, on demand, by considering and advising whether they can have a program or what is wrong with an existing program.

6. *General Practice Programs.*—The Advisory Committee clearly defined the rotating internship as the first year of a minimal training period of two years prior to practice. It did not enter the area of general practice residencies but members felt that though most internships are twelve months long, a man going into general practice should have at least one more year. A committee organized by direction of the House of Delegates to study the best background preparation for general practice is reporting in June on a new family practice program. It will be somewhat different from the general practice program and will use the word "family" more than it will use "general." Internal medicine and pediatrics are the basis for this program, with training in the management of emergencies and of trauma with obstetrics as an elective.

7. *Medical School Curriculum.*—There is talk of condensing medical training from eight years to six. Also, the internship has been merged with the clerkship in the medical school training in several places. The Council questions that this is the best type of training for the fourth year student. Medical school training certainly is concerned more with fundamentals and less with facts and techniques than formerly. The effects of clerkships on the conduct of internships is being actively investigated. Experience with research methodology is now available in some schools but many practitioners have no idea why medical students are exposed to research. They do not appreciate the beneficial effects an understanding of research philosophy and correct application of scientific method can have on the private practice of an individual.

8. *An Intramural Approved Program Versus an Integrated Approved Program Involving More Than One Hospital.*—It is becoming more difficult for even some university hospitals to maintain approval for a completely intramural program. The intrusion of private patients in the public wards, a different kind of outpatient, the absence of outpatient departments in some hospitals, the need for special facilities in rehabilitation, chronic disease, *et cetera*—all of these are causing institutions to combine their facilities for one top-notch program. The only requirement for this type of program is continuity. The number of buildings does not matter if it is the same program, the same staff, and if it is continuous. The result is stronger programs in individual communities and less of the competition between hospitals that has become very unwholesome in some instances.

Q.—If a given hospital does not have one-fourth of its quota of interns, can foreign graduates make up this difference?

A.—Yes. There is no discrimination between foreign and state graduates. They do not have to come through the matching plan.

Q.—Will you comment upon the substitution of a preceptorship type of education perhaps supervised by the affiliated medical schools as to its quality and qualifications?

A.—Most review committees view with concern the preceptorship idea. There still seems to be need for the preceptorship, but few hospitals seem able to organize a sound one. Many program directors have visited our office to ask whether it would be acceptable if the hospital staff were to use facilities in the hospital for following up their previously hospitalized patients, in association with the house staff. We feel this would be more desirable than having the house staff vibrate around town trying to follow patients in the offices of private physicians. If an intern only sees a patient during the hospitalized part of the illness, then he certainly does not learn the course of disease. He does not get "follow-up" training, particularly with surgical patients; furthermore, he has no opportunity to really learn the diagnosis and care of patients over a period of time on an ambulatory basis without ever bringing them into the hospital. We must try and simulate the conditions of office practice when a hospital has no outpatient department.

Q.—Integration between hospitals in the education program?

A.—It is due to the changing nature of the patient load and partly to the entry of the Federal hospitals into the training picture. With training programs at Veterans Hospitals supervised by medical school faculties, it became perfectly logical to try and merge those programs into one program under two roofs. To remedy the deficiencies, the institutions had to get together so that when one did not have the clinical material needed for training the other could supplement it.

Q.—How extensive is it now?

A.—It is not limited to university hospitals, but it is growing every year. This sort of affiliating has been going on for many years but has not been so identified in the Directory.

The Role of a Director of Medical Education

John C. Leonard, M.D.
Director Medical Education, Hartford Hospital
Hartford, Connecticut

THE WORK of a director of medical education—or the director of intern or house staff education, or whatever he may be called—is not simple. Actually, to attempt a brief definition I would say that his task is to organize, coordinate and supervise the educational program of the hospital in cooperation with and assisted by the intern or house staff committee, the hospital staff and the hospital administration. This obviously cannot be a solo job if it is to be done properly.

For any hospital program to function effectively the viewpoint of the house staff, the "satisfied customer," so properly mentioned by Dr. Nunemaker, must be kept in mind. These are the people who must be relied upon to sell programs to third- and fourth-year medical students in their schools. Therefore, it is word-of-mouth advertising from satisfied interns and residents that make the difference between success and failure in training programs.

The report forms sent to interns, often to residents, by the dean's office of the medical school are returned and kept in a permanent file for inspection by third- and fourth-year students in that school. If these reports are good, we have frequent visitors from the schools; if they are poor, we have few or no visitors. We believe in this system but wish that more schools would also ask for reports about the work of interns and residents who are their graduates.

For an educational program to function effectively, there must and will be improvement of patient care. We hear much talk about a house staff that is really being educated and trained, or is being used as "hands and feet." Our attitude as hospital staff toward this is another strong determining point in whether we will have intern and resident applicants.

All of us who have taught, whether in the medical school, the community hospital or university hospital, recognize that the teacher learns the most. The attending staff man who takes time to really teach, deliberately, carefully and enthusiastically, gets the greatest amount of stimulation. The corollary is the stimulation he passes on to grateful youngsters who recognize those who are truly interested in teaching and those to whom it is a painful duty.

It is often overlooked that for a program of medical education to be successful it must have participation at all levels of the house staff and the attending staff. The interns, assistant residents, residents and

the junior and senior attending men should take part actively in all discussions and in each clinic, formal or informal. One thing our hospital finally has been able to do is to discard seniority as the determinant of chiefs of services and promotion along various department levels. Initial appointments to the staff as well as annual reviews for promotion are based, by bylaw, upon the individual attending physician's interest and devotion to the teaching and research programs of the hospital. Personally, I think this is the strongest bylaw we have ever been able to have adopted by our staff.

What does a program of this kind mean to the hospital administration and its board of directors? These are the people, generally, who must foot the bill. We have found, across the country, that the cost of intern and resident training program is two to five per cent of the hospital's budget. Our present budget is two and a half per cent; we are still working to increase it. The late Dr. Alan Gregg stated that ten per cent of a total hospital budget was not an excessive figure to devote to house staff and postgraduate training because the actual welfare of patients depends entirely upon how actively the attending staff, stimulated by teaching house staff, keep up with their continuing medical education.

Should a director of medical education be full or part time? In these days physicians are busier than ever, not only with their own professional work, but also with greater segments of their time being taken by civic responsibilities. If the hospital is large enough, the hospital and its staff must decide whether to have someone who will try to carry on the organization, supervision and coordination of the program, or whether a highly devoted house staff committee or interns committee still can do this. In New England, we have now a fair number of directors of medical education who have this responsibility in two or three hospitals.

Should the director of medical education be an internist, a pathologist or a surgeon, or should he be a respected, retired member of the staff who won't meet much opposition, or should he be a youngster reasonably fresh after residency training program with lots of vim and vigor? Again, this must be decided by the hospital and its attending staff. Obviously, no matter how good a teacher he is, or how well-rounded, an internist cannot teach surgery, or pediatrics, or obstetrics; therefore, he must have the constant cooperation of his house staff committee, preferably with an excellent liaison representative from each staff department. Actually, the director of medical education must do most of his teaching by precept and example. My opinion regarding the primary requirement in a director of medical education is that he should be a catalyst. I like this definition of a catalyst: "a catalyst is like a shotgun at a wedding; it doesn't necessarily take an intimate part in the procedure, but it certainly does speed up the action."

The position of the D.M.E. on the attending staff must depend upon his age, experience and ability. Certainly we are not going to attract good people to this field if they are given inferior positions on professional staffs. The director should be chief of his department of medical education, with voting status equal to that of the chiefs of the departments. He must be given adequate authority by the professional staff, the administration and the board of directors. I have a strong feeling that the director of medical education should be a member of the staff executive committee. It is not essential that he have a vote, but he should at least sit in the meetings so that some situations which later would become mountains of trouble can be nipped in the bud. I think also, to make his work effective he should be a member of the administrative group or management committee.

I think something should be said about what a director of medical education should *not* be. He should certainly not be just a procurement officer. If his only task is securing interns and residents, and if that task is completely shrugged off onto his shoulders by the professional staff, failure is certain. I think the best directors of medical education do their part on the wards. If they are internists, they should make ward rounds on medicine; if they are surgeons, they should make ward rounds on surgery, pathology and radiology. As long ago as 1942 our chief of pathology was asked to go on ward rounds once a week, pick holes and flaws, take part in discussion and ask embarrassing questions about excessive demands for laboratory work that exhibited the non-thinking type of education that sometimes develops from today's highly organized laboratory-work in medical schools. The director of medical education must not be just a clerk and bookkeeper.

Likewise, the director of medical education should not be merely the policeman upon whom the attending staff shrugs off all embarrassing and punitive duties. He must not be known just as a "company man," an administrator's boy. If this happens, he loses all standing with the professional staff and one of the greatest difficulties in being a director of medical education is keeping the attending staff from being

suspicious because he is part of the administration and keeping the administration from being suspicious because he is part of the staff.

A director of medical education must be tactful. He must be willing to take the blame for things for which he is not entirely at fault. Diplomacy, patience and willingness to accept hard tasks are necessary in this work. A director of medical education will not have time for things all of us here would feel he should be doing if he must be the person responsible for student and graduate nurse education or even education in the numerous paramedical fields of today.

Panel Discussion

Objectives of an Intern-Resident Program—Education or Service

Moderator: Harry A. Towsley, M.D.
Associate Director, University of Michigan, Department of Post Graduate Medicine
Ann Arbor, Michigan

Q.—Where does service end and education begin, or vice versa, in an intern-resident program?

A.—Dr. Nunemaker—I hate to hear people say that service and education are mutually interdependent. I prefer to say that they are one and the same. In the Veterans Administration, research was an intimate part of every graduate medical training program environment. It is a custom to say that these are a tripod, one depending on the other, but I prefer to call them a trinity because research, education and service cannot be separated. The degree to which these three are one, the brightness of the flame with which they burn, is the measure of the quality of medical care.

Dr. Leonard—I know a lot of the things that we were expected to do are today considered by medical school graduates as "scut work." I think it is wrong to expect interns or residents to occupy their time in the hospitals doing what can be done by technicians trained for six to twelve months. But that, too, can be carried to an extreme because some medical students have no knowledge other than the theory of hematology and clinical pathology because they have not been responsible for urinanalyses, blood counts, et cetera. Under our supervision, and not as an excuse for their doing work that we do not want to be bothered with, they can learn a lot. Today's graduate can tell you, right on the nose by prediction, what the lactic acid dehydrogenase is going to be, but he will look at you blankly if you ask him if a gastric analysis has been done or if such a simple thing as a test for occult blood in the stool has been done at the original rectal examination.

I, too, do not think it is possible to separate medical training and service to patients. We get into trouble when we shrug off all the work that slightly trained technicians could do onto people who really should be trained in things that are increasingly difficult in this rapidly growing field of medicine.

Q.—Education versus Service in Residency Training? (continued)

A.—Dr. Bates—Far be it from me to alter the philosophy already expressed by the experts. One issue about the time element: taking away the responsibility for a certain amount of scut work has created idle time which has been interpreted as implying a time limit for duty. I think there is something sinister in introducing the element of the time clock in the educational process. The new physician must learn that service must continue around the clock, seven nights a week.

Dr. Leonard—A resident cannot be trained on a nine-to-five basis. It was most disturbing to me when I was told by a member of the American Board of one of the surgical sub-specialties that they were increasing their requirements from three to four years because they could not keep residents in the hospitals long enough during the day and at night to give them adequate patient contact and training. To me this is utterly ridiculous. You must see patients daily, constantly and regularly, and follow them throughout, before you actually begin to know anything about medicine. A criticism formerly directed at Veterans Administration hospitals was that too many residents were on duty from nine to five, with perhaps only one night per week on duty and one week-end of seven or eight. Dr. William Middleton reminded others that they had only to look at university and non-university hospitals to find that this is widespread. Unfortunately, this is true. It is a product of the times,

---

Members of the Panel included Gaylord S. Bates, M.D., Chief of Staff, Receiving Hospital; Roger W. DeBusk, M.D., Director, Grace Hospital; George O. Clifford, M.D., Assistant Professor of Medicine, Wayne State University, College of Medicine; John C. Leonard, M.D., Hartford, Connecticut; John E. Nunemaker, M.D., American Medical Association, Chicago, Illinois.

part of the socio-economic revolution. Those of us who are dedicated to the principles of medical education must make this part of our constant battle. I feel, and one of our residency review boards is taking this stand, that there must be a minimum of not less than alternate nights and alternate weekends of duty.

DR. NUNEMAKER—Let me read from the report of the committee of which Dr. Leonard was a part. "We see no intrinsic value at all in the recently past era in which in certain hospitals an intern was lucky to get out every six weeks for a hair cut and if married, by hospital rules, had to live beyond a radius of 100 miles. But we find ourselves in lack of sympathy with the nine-to-five attitude prevalent in most house staffs since World War II. The important phenomena of disease simply do not occur on a nine-to-five basis, and they do not follow a regular schedule having a night off. If a schedule set up for convenience is interpreted as an immovable law and independent of the patient's needs, the internship fails to provide the vital aspects of future medical life. If there is general abuse of the present buyer's market for the intern and if the nine to five attitude becomes more prevalent, it is not beyond our conception that many hospitals with fine educational facilities and a busy attending staff will find it easier to get along without them (interns)."

DR. CLIFFORD—I agree with everything that has been said. Forty years ago the student had little contact with the patient but now he has contact on a fifty minute basis so that he can get to his next assignment. As a result he wants responsibility but he doesn't want to accept it for the patient. Perhaps we should start talking to the deans to see if there is not some way to give greater responsibility to the man while he is an undergraduate. The medical school has stolen the glamour of the new patient from the internship, yet it has not accepted the responsibility for the care of the patient in this student-patient contact.

DR. NUNEMAKER—The majority of medical school departments at the clinical level are trying to arrange for the student to have nights and weekends on call so that he is responsible just as an intern would be, all the way through. This is not true of every department of every medical school, but it is true of some departments in most medical schools.

DR. LEONARD—There are some hospitals with excellent educational programs where, if the intern is going to do the history and physical he is going to do it tonight because he is sure that tomorrow morning the patient is going to be discussed. In a hospital where bedside teaching is very poor, the boys think that no questions will be asked and why bother writing it up tonight. I think if the staff really works the boys will spend much more than forty hours per week working.

DR. CLIFFORD—"Scut work" is a phrase we would do well to abolish. We have spent much time trying to teach medical students that the tools of his trade are the history, the physical examination and appropriate laboratory work. If we permit this to be defined as scut work and allow externs to do it; if physicians are too busy to complete their records; and, if we tell the nurses to take the blood pressures and call the doctor if there is a change, we make very serious errors. A physician does not just take a blood pressure—he evaluates a patient at the same time. When students look for internships they often think in terms of a fifth year of medical school, of instruction and supervision and teaching. I think a most important thing in any internship is the attitude, quality, and caliber of the staff as well as the availability of patients and a variety of clinical material. Without the appropriate attitude of the staff any elaborate program, although it may look well on paper, is going to be dead on its feet. The medical school does not wind up its job by handing its men M.D. degrees—it should stand ready to handle postgraduate education different ways, some of which have not yet been defined.

Q.—How can we stress outpatient treatment when we all know that outpatient departments do not have the wealth of material they had formerly?

A.—DR. NUNEMAKER—The Advisory Committee Report points out that hospitals are finding it mutually beneficial to create facilities, adjacent or very nearby, for their attending staff, not only for better care of the hospital patients but also so that these private patients can be seen in conjunction with the house staff in the environment of former outpatient departments. This is increasingly common. The plans for a new hospital area in a Chicago suburb include a multi-storied office building for doctors who can use the hospital lab, x-ray facilities, *et cetera.* This is to create a local environment in which out-patient experience can be given to the house staff, since they are sure they will not need the orthodox outpatient department. Another way is by hospitals affiliating; with the length of patient hospital stay falling, some way must be found to teach medicine increasingly on ambulatory patients.

Q.—If training with ambulatory patients in the doctor's office is accepted and if continuity over six to eight months is developed, does this not limit the number of house staff doctors being taught and wouldn't it be better to limit the continuity to three to four months in our offices?

A.—DR. NUNEMAKER—Continuity of three to four months is better than three to four weeks. In its report, one of the three fundamental principles the committee stated was continuity of contact with the men best qualified to teach, in contrast to rotating assignments of one month or two months to a variety of men who really never learned the name of the house staff officer. Somewhere the decision has to be made to limit the contact of the interns to those men best qualified to teach when all of the attending staff claim they have the right to the time of the intern.

DR. LEONARD—Men on various medical school faculties seriously doubt how much a medical student or intern can get from sitting in their offices looking over their shoulders, especially in a short period of time. Probably this merely means that most doctors and their patients aren't as comfortable in the presence of a third person. I think it would be smarter to think in terms of having an adjacent hospital section where this type of outpatient follow-up can be carried on rather than trying to distribute interns and residents

through numerous physicians' offices. In the problem of assigning interns or residents to too many physicians on an in-patient basis we face the same thing. We have solved that to a considerable degree by saying that our large ward and semi-private teaching floors shall automatically constitute the teaching population.

Q.—Wouldn't it be wise to ask a man to re-evaluate his training five years out of his training program—he would then be competent to do it?

A.—One of the devices the Advisory Committee used to secure information was to poll the entire graduating classes of 1937 and 1947. The responses to the question, "from a list of ten defects list in the order of importance the defects of your training program"; from both classes were: 1. lack of supervision, 2. few teaching exercises, 3. program lacking responsibility, and 4. heavy patient load. The 1937 graduates' replies showed that 43.1 per cent of those who had taken straight internships wished they had had rotating internships.

A four month medicine assignment separated by other services—one month medicine, one month surgery, then another month medicine, *et cetera*—is usually caused by the heavy load of the hospital in the particular service. This is seen in large city hospitals, and the program gets perverted because of the service needs of the hospital so that continuity in one service is broken. In general, we say that medicine should equal or exceed the time on any other service. No service (major) should be less than two months. Ordinarily four months on medicine, and either three or four months on surgery, two on obstetrics and two on pediatrics is pretty much the standard pattern, with perhaps a month or so of elective and with psychiatry and outpatient related throughout the entire program.

Q.—What progress is being made in using paying patients in teaching programs?

A.—Dr. Nunemaker—A Committee of the Association of American Medical Colleges has considered the question of using paying patients in teaching programs to the point of whether the house staff can charge. The suggestion I like best is to have the patient told that his care cannot be given by just one man but that it is a team effort. Obviously, the private surgeon could no more single handedly perform the surgery on that patient but must have a team with him. It should be presented to the patient in that manner with the statement that this senior resident is going to be the captain of that team and the surgeon will be a member of the team. When the patient does not know that the resident is to be the principal operator and the consent is not sought, this then becomes ghost surgery. There is great unrest concerning this.

Dr. Leonard—We have had the same arguments. We teach with 100 per cent of our patients. We still have a hard core of surgeons and obstetrics men who will not go along with this concept, but this number gets smaller every year. One thing that has impressed me is that the intelligent patient appreciates having two or more people looking after him rather than just one.

Q.—How do you get the surgeons to do daily bedside teaching in your hospitals?

A.—Dr. Leonard—If we did not have a by-law whereby a person's original appointment to the staff (this includes all specialties) and the annual renewal depends upon his taking part in the teaching program, we could not get the surgeons to do bedside teaching.

Q.—How should an intern committee be selected in a given hospital?

A.—Dr. Leonard—I hope I made it very clear that there should not be just a director of medical education. It is still the habit in most hospitals to have that committee consist of the chief of each major service. I have nothing against this except that the chief of surgery and the chief of obstetrics may be so "whipped" by the end of each day that they have little energy left for problems that require enthusiasm and hard work. Therefore, it is my feeling that the specialty department should choose its most able and enthusiastic person to work on the house staff committee. That person, in turn, could have constant and frequent consultation with his chief of service.

Q.—Should this education committee have more than one year's tenure?

A.—Our graduate medicine committee, because it takes in the whole gamut of house staff training, has worked together for five years. Its predecessor committee worked for the preceding seven. I think there must be continuity. If there is complete turnover every year, as with any staff's executive committee or any board of executives committee, it ruins continuity and quality of the program.

Q.—Is the director of medical education of equal importance to a university hospital as to a non-university hospital?

A.—Dr. Leonard—I think that while some university hospitals have appointed directors of medical education, they usually are appointed just as coordinators rather than as active teachers and participants. The need is largely in the non-university hospital that does not have a full time chief of service and a dean to take up the slack that the non-university hospital does not take care of unless it has either a director of medical education or a devoted house staff committee willing to spend massive amounts of time.

Q.—If an intern program includes affiliation among several hospitals, isn't it an AMA intern requirement that a certain amount of time be spent in the home hospital, and if so, how many months?

A.—Dr. Nunemaker—This idea of integration has developed far more in residencies than it has in internships, but we're going to see more and more of these indented listings applied to the intern program. The term "parent hospital" is used most frequently in relation to an affiliated hospital in the sense that this hospital affiliates, has no approval of its own, but is used for not over 25 per cent of the total time for training in a particular area that the parent hospital doesn't give. To use surgical residencies, for an example, it is not infrequent for a particular hospital to be very well equipped for gynecologic surgery, whereas the parent hospital may have very little provision for gynecologic

surgery. That other affiliated hospital then may participate simply as an affiliate for a few months or a short period of time in the program, and if it is an affiliate, then the other one that has the approval is the parent. However, if those two hospitals were quite comparable in many respects, and banded together in one complete program where perhaps an equivalent amount of time was spent in the two, or three banded together where an equivalent amount of time was spent in all three, this if presented as an integrated, combined, unified, single program, would be quite acceptable.

Q.—What is the intern-patient ratio mentioned by you earlier?

A.—Dr. Nunemaker—The *Essentials* state that training hospitals should have at least 150 beds and at least 5000 annual admissions, and one intern should not be responsible for less than fifteen or more than twenty-five beds. This, of course, must be considered with the size of the hospital, the rest of the house staff, the existence of other residency programs and how much time is spent on non-ward activities. So, in a 150-bed hospital fifteen beds per intern would require a house staff of ten; for twenty-five beds per intern the quota would be six.

Moderator—I think that answers the question whether the small hospital has a significant role in medical education. I think we could say that it does, insofar as internship is concerned. I would like to have you comment on this in relation to a residency program.

Dr. Nunemaker—When general practice residency programs were inaugurated some years ago, a great effort was made to encourage such programs and some were approved in hospitals considerably smaller than 150 beds. To one that had only fifty beds, I wrote a very critical letter at the direction of the committee because the hospital had twelve residents, mostly Mexican. In the *Essentials of Approved Residencies*, requirements for clinical experience in a particular specialty are not recited so often in terms of beds as in admissions or some type of clinical material being available. In general, residency programs are not fully approved in hospitals smaller than 150 beds. Unfortunately, we have a large number of one or two year programs in surgery, medicine, pathology and obstetrics. The Council now is considering whether certain of these programs should be disapproved. A growing tendency regarding residency in specialties has been to approve for the full period or not at all.

Moderator—Many hospitals having approved three year surgical residencies or two year OB residencies are having difficulties getting residents other than foreigners because they do not have an additional year. Do you have any idea of how long the shorter programs are going to be maintained?

Dr. Nunemaker—I believe it's the sentiment of many that it would be desirable if all surgical programs were four years. Apparently, it is just not feasible in many situations where a three year program can be thoroughly sound. I don't know of any change contemplated at the moment. The one and two year programs were originally approved for the primary purpose of providing general surgery for the man planning on further surgical specialty training. These partially approved surgical residencies are being used to a minor degree by men who seriously expect to go on in a surgical specialty.

Q.—Moderator—*If you and the chief of the service do not agree on an important aspect of a residency program, how is this dilemma resolved?*

A.—Dr. Leonard—I have a standing policy with the house staff, which I think is a part of both diplomacy and humility, that any time I am voted down I gracefully accept it. If there is a difference of opinion between the chief of service and myself I always very humbly ask why not take a vote on it. So far, 100 per cent of problems have been resolved in this manner.

Q.—Dr. Clifford—*What would be an appropriate salary for a Director of Medical Education in a community hospital, full-time and part-time?*

A.—Dr. Leonard—In this year, 1959, I think that if your hospital wishes to attract as Director of Medical Education a well trained person with ability and ideals, who is enthusiastic and devoted, you should consider paying him $25,000 a year. If the position can be carried on a part-time basis the range should be up to $10,000.

Q.—Dr. Buerki*—*May I go back to diplomacy and humility? As an administrator I see many people trying to solve a problem when it arises without having had a clear mental picture of where they are going and how things are to be resolved before there is a problem. I am impressed with the fact that when there is a problem emotion gets involved and the best answer rarely emerges. Diplomacy and humility do overcome a lot of shortcomings but I like to see problems anticipated and decided on a democratic basis by the staff.*

A.—Dr. Leonard—I would agree entirely with Dr. Buerki. A Director of Medical Education can have no value if things are not spelled out in advance. He must have a position on the attending staff with authority which is understood and accepted and he must be on the administrative staff with a vote. Without these his ability and humility are going to be completely negated.

Dr. Nunemaker—At a meeting in Chicago the question arose of whether the "D.M.E." should be a board diplomate. I think there was general agreement that he should be a diplomate of the board of diplomacy.

Q.—Could you list criteria for selecting instructors for a program—specialty versus general practice?

A.—Dr. Leonard—In my area we have so many specialists that the general practice doctor takes one year of rotating internship and then a one year residency in medicine because in very few places can they do surgery unless they are Board certified. Except in an area where the family doctor has to do everything, the second year can well be spent within the Department of Medicine. As to instructors I think

*Substituted for Dr. DeBusk.

I indicated earlier that the Director of Medical Education, with the constant support of his committee, should choose people from each department on the basis of background, training, enthusiasm and teaching ability. Unfortunately, there are some in every area who really would love to teach but cannot; they should not be put into the position of being asked and having the house staff say: "We know he knows his stuff but he can't get it across."

DR. TOWSLEY—We have a two year general practice program which includes internship. We do not call it a residency—in fact, we have not applied for approval. We make every effort to utilize the services of general practitioners in the teaching program. In one hospital in which there were no specialists our program failed miserably. We feel that board qualified or board certified men in the various specialties are essential to a teaching program. We also feel that the general practitioner is a very integral part of this program because he can do very well in bedside teaching and the practical approach to many points. Another very ulterior motive for wanting the general practitioner to be a part of the program is that the man who teaches has to read; the man who reads betters himself and does his own postgraduate education. If the family doctor is part of the team he will do a better job of practicing medicine—he will read, he will study, he will attend CPC, x-ray and clinical conferences if he is part of the teaching team. As a whole this raises the standard of medicine in the community.

Q.—To what extent should research be a part of residency training?

A.—DR. LEONARD—Research often is thought of as purely laboratory procedure. While that is important, I have been impressed by the number of youngsters who, with suggestions on ward rounds, delve into medical records of the preceding five to twenty-five years. If there are excellent medical records then a form of research is possible which often produces extremely valuable information not only for the person doing the work but also for the entire hospital and often the community.

DR. CLIFFORD—The critical attitude and habits of mind which are characteristic of research activity would very well apply to the evaluation of patient's problems and therapeutic results.

Q.—How does a Director of Medical Education determine whether the various departments are doing satisfactory teaching?

A.—DR. LEONARD—We have faced this problem many times. Once each year the House Staff Committee evaluates residency training programs and the internship program, based upon comments requested from the residents in each department and from our 18 rotating interns. From this constructive criticism we actually get magnificent material and suggestions for improvement of our training program.

In 1954 we attempted to learn from fourth year students and interns the things which they thought were most important in an internship. First was the quality of the training program. Sixth and seventh were salary and living quarters. In 1958, similar questionnaires showed that the quality of the training program was still first, with living quarters for married interns and residents second and salaries third.

DR. TOWSLEY (concluding)—Dr. Saltzstein and his committee organized this program because we feel that in Michigan we have a real problem. We have a hard time attracting interns and making our internships appealing to prospective candidates. We would have 680 interns in the state if all of the hospitals filled their quotas. On the matching plan we received 360 interns, which gave us a little better than 56 per cent in the state as a whole. Meetings such as this will help us do better by getting to the crux of the problem.

Course in Hospital Management

A course in hospital housekeeping will be given April 4-May 26 for the twelfth consecutive year at Michigan State University, East Lansing, Michigan.

The course, the only one of its kind, is sponsored by the American Hospital Association in cooperation with the university. It will provide practical training in hospital housekeeping procedures for executive housekeepers, members of hospital housekeeping staffs and prospective employes. Enrollment will be limited to forty students.

The course will include the philosophy of hospital care and institutional organization, personnel management, institutional management, housekeeping supplies, equipment and procedure.

Applicants must be hospital employes or individuals promised employment in hospitals.

A total of 337 persons, representing 317 hospitals ranging in size from nineteen to 2,000 beds, have been graduated from the course during the last eleven years. The students have come from forty-six states, Puerto Rico, Canal Zone, the Netherlands, and seven Canadian provinces.

Ten scholarships are available, but too late for this year. Address Scholarship Committee, Huntington Education Fund, American Hospital Association, 840 N. Lakeshore Drive, Chicago 11, Illinois.

Hidden Occupational Hazards in Industry

Henry J. Kreulen, M.D.
Grand Rapids, Michigan

WHEN I entered the field of Industrial Medicine, industry was emerging slowly but surely from the depression. The number of unemployed was decreasing daily. From a low point of 15 million unemployed men and women, industry was emerging upon a scene of new technology with a strong emphasis upon the prevention of accidents and illness rather than upon the care of the injured. Not that prevention was something that was new and heretofore not stressed, but a new emphasis emerged. Along with the new processes, new materials, new machines, new products, and new chemicals there came a new demand on medical science—the relationship of man to his industrial environment was now the challenge that Industrial Medicine was to face. The meeting of this challenge did not come as a result of new laws being passed or new ideas being issued, but management voluntarily took up the challenge and began to study the relationship of the employe to his employer and to his working environment.

Thus has come forth and multiplied by leaps and bounds, a new employe, a new member on the team —the industrial physician. His task has not always been an easy one. As each year passed with greater rapidity (not only because of his increasing age but also because of the increasing tempo in industry, the rapid development of technology, the astounding increase in new methods, the tremendous discovery of new chemicals and new products) it became increasingly more difficult to keep abreast in this new age of medicine, technology, and humanity. But it is here that the industrial physician came into his own specific sphere of influence. It is his duty to keep abreast of the times in order that he may keep the worker healthy. This is done by keeping him in a healthy working environment. Furthermore, it is his duty to be able to advise the worker as to personal emotional management of his own relations at work, at home, and in his community associations. If the worker is not well he should be advised how to get well. On the whole, this task has been carried out by the industrial physician who furnishes thousands of services in industry with the backing of management.

In the United States *now* there are more than 12,000 chemical plants manufacturing in the neighborhood of 9,000 different products in commercial quantities. The industry employs over 1,000,000 people. In 1914 employment was 32,000; by 1918 these figures tripled as a result of World War I. Before this, our own and the chemical industries of the world were controlled by foreign chemical industries. European domination of our American markets was what our chemical industries had to face. However, America with the determination to win, finally developed a chemical industry second to none. So today we are producing thousands of organic and inorganic compounds and this brings a challenge to the industrial physician to keep up on the rapidly changing times and materials.

In the years following this chemical revolution there developed, through the efforts of medicine and engineering, the science of industrial hygiene and toxicology. Thus, from accident treatment the industrial physician emerged as an individual interested in prevention of disease and in assuring the American worker a healthful work environment. Through the study of air and chemical analysis of products, we have made it possible to use many agents which previously were harmful but can now be used with impunity. Thus, a new science has developed—industrial hygiene and toxicology. This is not to say that there are no longer injuries to treat; the accident rate is gradually improving; frequency ratings are being reduced. However, the emphasis is changing from the treatment to the prevention of accidents and illness. By means of this change in emphasis, new methods have developed which vitally change the environment of the American worker giving him advantages which no other worker in the world surpasses. But it also brings medicine and industry closer together to solve the problems which our new

Presented at the 93rd Annual Session of the Michigan State Medical Society, Detroit, October 2, 1958.

technology produces. Hazards are more closely evaluated and finally—with the help of engineers, management, and medicine—we are able to provide work areas so that disability and disease are rapidly being eliminated.

With the rapid development of new chemicals constantly replacing the old, it is even more difficult for the industrial physician to keep pace with the rapidly changing products being used. Add to this the fact that between 85 per cent and 95 per cent of the employes in American industry have no medical services available in the plant, we can see the great need of interested parties such as physicians to be alert to the toxic problems facing our workers today. Also these 85 per cent to 95 per cent of the workers are being treated by general practitioners who themselves state that they are unable to keep pace with the toxicology of new products and materials used in industrial processes.

This brings me to the next important point—what about these people who present certain symptoms which may be the result of toxic exposure to chemicals or substances used in their employment? What things are necessary for the general practitioner to know before he can make an accurate diagnosis? Let me briefly outline a few salient points. First, and probably foremost, the physician should know something about the working area of the employe. Is he exposed to any toxic materials and if so, what is the substance he is exposed to? If the substance is toxic the physician should be alert to the results of such an exposure. Are there any precautions or safety devices used by management to protect the employe so that his exposure is within safe limits and not the cause of his illness? Are the precautionary methods adequate or was there a possibility of a temporary break in the technique so as to expose the employe? If management is alert to the hazard and adequately protects the employe, then the physician can be assured the worker's illness is not the result of his working environment. Questions and observations of the worker in regard to his personal hygiene are in order. Is he careless in the use of the toxic material and is he making proper use of washing facilities, change of clothes, and helping management with good housekeeping? The reason the full-time industrial physician can be of help to the general practitioner is that he is acquainted with the work area, has personally seen it and knows whether or not protection is adequate. If no full-time physician is present, the family physician should make a personal visit to the work area which is just as important as a history or physical examination. The physician should acquaint himself with the material and determine the toxicity of it. This, of course, is determined also by the portal of entry. Some substances are absorbed through the gastrointestinal tract, others by inhalation through the lungs, and others through the skin. Is the exposure plus the probable portal of entry responsible for the toxic symptoms the patient presents?

A word of caution would not be amiss at this point. Most will agree that by far the majority of the employes are honest in their reporting and descriptions of the work they are doing. There are, however, those who will exaggerate the amount of lifting they are doing or exaggerate the amount of dust in the air they breathe or any other pertinent information regarding the working environment. Therefore, it becomes very important for the attending physician to personally acquaint himself with the work area so as not to be misled by the history in making his diagnosis.

Having determined the foregoing, the physician should be able to differentiate between the acute pulmonary edema as a result of heart failure and the pulmonary edema due to ozone or cadmium fumes. Whether his headache is from CO or lead or sinusitis, whether his convulsions are due to epilepsy or due to parahtion poisoning, his weakness and anemia might be due to benzol or lead but also due to pernicious anemia or leukemia. The bloody urine may be due to benzol or arsine. His anuria with high blood pressure, nausea and jaundice, and loss of vision might be due to chronic nephritis on a post-infectious basis or it might be due to carbon tetrachloride. His bloody stools could be intestinal influenza or ulcerative colitis but it could also be mercury intoxication. His chronic abdominal distress with abdominal colic and wrist and foot drop might be due to lead but other causes must be ruled out. Hence, the following injunctions:

1. A good occupational history is necessary for differential diagnosis.
2. See the work area and, if possible, the plant engineer.
3. Any poisonous substance can be handled safely with the proper precautions and safety engineering.
4. Remember the route of entry is by one of three roads—lungs, digestive tract or skin.
5. An ounce of prevention is better than a pound of cure.
6. Good housekeeping is an essential. Hazardous and disagreeable working environment are not unavoidable conditions of employment.

Let me not forget to mention the problem of failure to properly label materials coming into the plants. It is gratifying to see the A.M.A. Committee on Toxicology discussing the Uniform Hazardous Substances Act. Legislation should be passed requiring all packages having ingredients that are hazardous to be so labeled as to disclose the hazardous substances in them. How often we are confronted with the problem of approving a new substance—with only a trade name on the label and having no assurance of the absence of harmful ingredients except the say-so of the salesman or company representative. Then starts long weeks of correspondence. Many times, firms even refuse to disclose the active ingredients for fear of substitution or imitation. In July of this year, the Committee on Toxicology again met with representatives of Trade associations, toxicity testing laboratories, chemical trade unions, and other interested groups. We sincerely hope that the result will be proper labeling of the packages containing the harmful ingredients.

Anoxemia

One toxic substance which is more and more given the respect it deserves is carbon monoxide. We all know that it is formed as a result of incomplete combustion. The most common causes of non-industrial CO poisoning are from poorly vented gas heaters and furnaces, leaky or even stopped-up chimneys. Automobile exhaust is very common in industry where many small tractors are used and also the presence of floor furnaces. In some new welding processes where alloys of steel are welded, temperatures are achieved even to 4000° Fahrenheit. The presence of oxygen increases the number of imperfections and therefore a shielding process is used by creating a shield of inert gas to keep the oxygen from the weld. After using argon or helium, it was found that carbon dioxide (CO_2) was just as effective but much less expensive. Because of the high temperatures, CO_2 may break down and give off CO at the point of welding. In large areas where there is ordinary circulating air there is little danger but in confined areas there may be an appreciable exposure to CO. The maximum exposure acceptable is 100 parts per million.

We all know that the final result of exposure is anoxemia. This occurs because the CO combines with hemoglobin to form carboxyhemoglobin. The affinity of hemoglobin for CO is about 300 times that of oxygen, and the resultant carboxyhemoglobin is also much more stable. Therefore there is less transfer of oxygen and also less removal of CO_2 from the body in addition to certain effects on the function of enzymes and pigments.

There are several factors which increase the effect of a given concentration of carbon monoxide. Exercise is perhaps the greatest; length of exposure, another; and temperature and humidity, another.

Regarding pathology, the anoxemia which is produced results in changes in all the end organs and especially the blood vessels. The capillaries are particularly affected by a sequence of dilatation, increased permeability, edema and finally hemorrhage. Every organ is affected and damaged. The brain and heart are perhaps the greatest to suffer damage. Cerebral edema accounts for headache and dizziness and hemorrhagic encephalitis may result from large concentrations of CO. Cardiac damage usually involves the conduction mechanism and coronary vessels. Even coronary thrombosis may result. Similar changes can be seen in all organs—skin may show blisters and petechial hemorrhages. It is well that we be alert to the possibility of CO poisoning, especially where motors are running (whether diesel or gasoline), in areas where air is not freely circulating. The employe who complains of headache, nausea, and a tired feeling might well be suspected of CO poisoning. Marked weakness and collapse may confuse a physician who feels it may be anemia or heart failure.

Solvents

It would take years of study to be well acquainted with all of the solvents. There is one characteristic they all have, and that is also the property which makes them toxic, that they dissolve fats. This means that they will penetrate skin on contact and gain access to the blood stream. Thus, we must not only consider absorption but also the inhalation of vapor. This property of fat solubility explains the accumulation in parts of the body that contain the most fat, thereby producing anesthesia, unconsciousness, paralysis and death. The second property of solvents is that those chemicals which normally exist in the body as a result of food absorption or are products of metabolism of food are less likely to produce poisoning when absorbed from the working environment such as alcohol, glycerol, acetic acid, and lactic acid. The third property which is not only applicable to solvents but also to other poisons, is that pleasantness of smell is not a guide to the toxicity of the solvent.

Solvents may be divided into straight chain aliphatic hydrocarbons. These are the gasoline and kerosene type of solvents and their toxicity consists of skin irritation, defatting, asphyxiation, and anesthesia in confined spaces. Also commonly used are some aromatic solvents such as benzene, toluene, and xylene. Their vapors are much more toxic than petroleum vapors and their degreasing action more rapid and severe. Today, gasoline may contain as high as 20 per cent benzol, even in unsaturated chains and cyclic compounds. Therefore, when solvents contain this degree of benzol we may expect bone marrow damage in time, or headaches, weakness, paralysis of muscle, and changes in personalities and moods. Then we have the halogenated hydrocarbons. These include carbon tetrachloride, chloroform, and the chlorine derivatives of ethylene and ethane. In general, the addition of chlorine to straight chain hydrocarbons lessens the inflammability, increases the narcotic effect and increases the toxicity especially to kidneys and liver.

One can hardly discuss toxicology and toxic substances without coming in contact with carbon tetrachloride. In 1923, nearly 11 million pounds of carbon tetrachloride were manufactured in the United States. By 1930 the quantity had nearly tripled. A large chemical company in 1951 estimated their production capacity to be 224 million pounds per year. By 1958 this may well be 400 million pounds per year. The history of carbon tetrachloride is very interesting: —from its origin as an anesthetic and analgesic to its use as a shampoo because of its grease dissolving properties; then as an anthelmintic for which it was used some ten years ago to the present industrial usage. Most of the uses of carbon tetrachloride in industry are dependent upon its quality as a solvent for such materials as oil, grease, fats, waxes, rubber, paints, lacquer, asphalt gums, and resins. Its degreasing ability accounts for its use as a dry cleaner, dry because it vaporizes quickly and superior to gasoline and naphtha because of its non-inflammability. Its large use is as a fire extinguisher. Since it does not conduct electricity, it is useful in fighting fires near electrical equipment where water might cause short circuiting. Phosgene, a decomposition product of carbon tetrachloride, is a poisonous gas and must be guarded against when carbon tetrachloride comes in contact with heat in a small area. Carbon tetrachloride is also one of the raw materials used in the production of Freons which are used as refrigerants.

The symptoms of acute intoxication are characterized by sudden unconsciousness which is followed by either quick recovery or death. Usually the heart exhibits extra systoles or ventricular fibrillation. Those symptoms that follow in a day or two are due to severe destruction of the liver. However, the most important type is that of subacute poisoning—the most numerous and the most dangerous. One factor which is important in these cases is the aggravation of toxicity in those cases where alcoholism is a factor. The kidneys frequently show lower nephron type of damage. Other changes are found in the liver, bowel, and brain. Most common symptoms are vomiting, nausea, abdominal pain, headache, edema, fever, and jaundice; signs are albuminuria, rise in non-protein nitrogen, hematuria, and pulmonary edema. The third type is the chronic exposure and that is the type most often seen in industry. They are also not as clear-cut and therefore frequently not recognized. Mental dullness, ambylopia, cirrhosis, and gastrointestinal symptoms frequently predominate the picture. Death is due to hepatic failure as shown by deep coma and jaundice. In industry we must be alert to this exposure. Carbon tetrachloride is frequently used as a cleaner of greasy and oily machinery. Motors are frequently sprayed with solutions most of which contain varying amounts of carbon tetrachloride. These should not be used if possible but if no other means exist, should be used where either cross ventilation is adequate or in spray booths where there is no possibility to inhale the toxic substance. The use of carbon tetrachloride in fire extinguishers in enclosed areas is also to be discouraged because of phosgene which may be generated.

Cadmium Poisoning

Another toxic substance which I would like to discuss briefly is Cadmium. Cadmium poisoning occurs more frequently in industrial operations than is commonly recognized. The metal is soluble in acid and is very rarely used as a pure metal. Its modern use is mainly as a constituent of alloys or in compound form. It is also capable of taking a high polish and is resistant to corrosion and rust. Therefore, it is frequently used in electroplating. In industry, the usual hazard is in the form of dust or a fume and the portal of entry is the respiratory tract. Incidence of poisonings are increasing because of its wider usage, and are seen in the making of alloys, metal plating, spraying, and welding—thus exposing platers, solderers, refiners, and smelter workers. In 1953, Amdur and Caputi of Buffalo, New York, re-

ported a group of four in which exposure was a metallizing procedure by means of which cadmium was melted in an oxyacetylene flame and then deposited by being blown against a rotating spindle. Because of the small spindle, about 60 per cent of the metal dust was dispersed in the room. In this instance, the offending material was the metal as distinguished from the fume. All four persons recovered. In 1958, Colter of New York, reported three cases with recovery in all. One was a chemist who worked with finely powdered cadmium. The second was a plater's helper and the third was a pigment mixer who used cadmium sulfide.

The use of cadmium in the ordinary plating operations at ordinary temperatures is harmless but when fumed by burning, the small fume particles are inhaled deep into the lung where they have the same effect as phosgene. The result is a diffuse burn of the entire lining of the lung with the outpouring of fluids and is difficult to distinguish from cardiac failure with pulmonary edema.

The first symptoms of acute cadmium poisoning is a distressing cough followed either quickly or possibly not for hours by headache, dizziness, shortness of breath, and a feeling of tightness in the chest. Dryness of the throat as well as nausea or vomiting may also be seen early. Later there are chills reminding one of metal fume fever. When the lungs are so severely damaged that oxygen can no longer combine with the blood, there is fever and the patient dies. Marked mental irritability may also be present.

The inhalation of dust or fume is the cause of the above symptoms. Cadmium is highly toxic and causes severe damage to the terminal air sacs of the lungs. Further pathology is seen in liver, kidney, and bone marrow function. Elimination of cadmium is slow and protracted, suggesting a tenacious binding in the tissues.

Antimony Poisoning

One toxic substance of which one hears very little is antimony, and also called Stribium. It is usually found as a sulfide. It is soluble in hot hydrochloric acid. It is used extensively in alloys because of its peculiar property of expanding upon cooling, a property which is just opposite of that found in most metals. This property makes its use valuable in printing type metal. Antimonial lead is used in the storage battery industry and in metal bearings. Shot, colors, paints, enamelware, munitions, and chemicals contain the metal. Frequently antimony trisulfide is used in the place of lead.

Poisoning occurs as the result of contact with the powder or dust of antimony or its compounds. The dust gets on the skin, in the nose, mouth, or throat, and then is ingested. This results in possible nasal ulcers or acute stomach and intestinal disturbances, or both. Antimony metal and compounds are irritating to skin and mucous membranes and is considered a systemic poison. Action is similar to arsenic and lead, and also gives a metallic taste in the mouth, vomiting, colic, loss of appetite and weight, but diarrhea is much more common. Chronic poisoning produces a reduction in white blood cells and damage to the liver. Because arsenic is frequently an impurity of antimony and because lead is frequently found as an alloy with antimony, the complications and toxicity of the two agents are confused with antimony exposure. However, it is fortunate that the treatment for arsenic and antimony is essentially the same.

Arsenic Toxicity

Because antimony and arsenic are closely related I would like to briefly discuss the toxicity of arsenic. The metal is silver grey in color, insoluble in water but soluble in nitric acid. The compound most commonly in industrial use is the trioxide. It is used extensively in the manufacture of insecticides as lead arsenate, Paris green, dyes, and rat poisons. The principal exposure occurs in smelting of ores. Acute poisoning is due to intentional or accidental swallowing of the ores. The poisoning in industry is due to chronic or prolonged inhalation and absorption of fine dusts or sprays. It is highly cumulative, being deposited in all the tissues of the body especially in liver and kidneys. Also in hair and nails where it can be detected about two weeks after the beginning of exposure and here it persists for months after the exposure is terminated. It is eliminated through the kidneys and can be identified within a few hours after the initial exposure in the urine.

The symptoms of arsenic poisoning are general weakness, headache, skin lesions, warts, ulcerations, sweating, loss of hair and nails, inflammation of eyes and mucous membranes of nose and throat, nausea and vomiting and some diarrhea, muscular weakness, and numbness of extremities. These symptoms are severe nuisances but seldom fatal or disabling.

Severe and acute industrial poisoning with arsenic are likely to be the result of inhalation of arsine produced when hydrogen is generated in the presence

of arsenic. This gas has been reported in the acid cleaning of filter plates, in the handling of wet dross from a light metals plant, cleaning of tank cars which held sulfuric and hydrochloric acids or in the precipitation of cadmium with metallic zinc. Arsine rapidly destroys red cells—after inhalation the first signs are lack of oxygen—then the body excretes red cells which show as a bloody urine and finally kidneys cannot function at all. The possibility of arsine formation should always be considered when there is hydrogen formation around active metals since arsenic is widely distributed in small amounts and only a trace is required to produce enough arsine to be troublesome. One of the common sources of arsine is in the handling of dross from the aluminum refining of metals. Another source is when zinc containing arsenic is dropped into hydrochloric acid resulting in the development of arsenious hydride or arsine. It is roughly twenty times as toxic as cyanide.

Conclusion

I have merely mentioned and touched on a few of the toxic materials found in industry today. In conclusion, I would like to suggest that if there is a safety and medical department in the plant with which you might be connected that no new chemicals are purchased by the purchasing departments without the approval of the safety and medical departments. This is perhaps the first line of defense. Frequently, unsafe materials (especially solvents) are used because some salesman or representative of the chemical firm advises their use and frequently forgets to mention the hazards involved or the toxic materials present. Injury may result before its toxicity is discovered. In your walks about the plant, do not minimize the use of the sense of smell. Many harmful contaminants are invisible to the eye. So use your eyes, your nose, and your throat to advantage.

300 36th Street, S.E.

Trials of Sabin Vaccine Start in Three Cities

Trials of the Sabin live-virus polio vaccine in this country are being made possible through three grants totaling over $300,000 in New March of Dimes funds.

The U. S. trials of the vaccine developed by National Foundation grantee Dr. Albert B. Sabin of the University of Cincinnati are being conducted in Houston, Tex., New Haven, Conn., and Cleveland, Ohio. The vaccine has already undergone limited tests in this country and extensive studies in the Soviet Union, Czechoslovakia, Latin America and the Far East. In the Soviet Union alone, the vaccine has been given to more than 12 million people without any reports of unfavorable effects.

Further tests on live-virus polio vaccine were called for last year by the U. S. Public Health Service and The National Foundation.

Reporting that the Salk vaccine is a safe and effective weapon against polio, the Public Health Service recently stated that a license will not be issued for any live-virus polio vaccine until certain questions are answered in detail. The National Foundation studies are designed to clear up specific points regarding stability of virus strains in the vaccine, administration schedules and the practicality of giving the vaccine to the newborn.

Unlike the Salk polio vaccine, which immunizes with viruses that have been chemically "killed," the Sabin vaccine uses strains of "live" but attenuated or weakened viruses.

The Sabin vaccine can be taken orally. It is expected to cost less than the Salk vaccine. It is hoped that the Sabin vaccine may give longer, more effective immunity and that it may possibly start the process of immunity more rapidly.

Under a New March of Dimes grant of $170,884 to Baylor University, Houston, Dr. Joseph L. Melnick is directing a community trial in which 4,400 persons will be studied, 250 of whom will receive Sabin's vaccine. It is known that live-virus vaccine can spread from the person who takes it to his family and other close contacts. Dr. Melnick will attempt to find out how many contacts will acquire immunity in this manner. He will attempt to learn to what extent the live-virus vaccine may "revert" to a more virulent state after passing through a person who is vaccinated and his contacts.

Under grants totaling $81,038 to Yale University, New Haven, Dr. John R. Paul is also studying the degree that live-virus vaccine may increase in virulence after passing through those who receive it. Dr. Paul's project, however, is primarily designed to provide information on how high a dosage and at what schedule vaccine should be given to assure that it will "take" in those who receive it.

Under a grant of $57,387 to Western Reserve University, Cleveland, Dr. Frederick C. Robbins' study deals with the feeding of live-virus vaccine to newborn infants. It will focus particular attention on what influence polio antibodies obtained from the mother may have on her child's response to the Sabin vaccine.

Three tiny vials of Sabin live-virus polio vaccine—less than an ounce—are all that Dr. Joseph L. Melnick needs for New March of Dimes-sponsored field trials involving 4,400 people in Houston, Texas.

Current Use of New Drugs in Anesthesiology and in the Treatment of Pain

John S. Lundy, M.D.
Rochester, Minnesota

IN contemporary practice, we have many agents and methods which permit us to produce anesthesia with a bright prospect of success—a prospect that is entirely different from the one we faced only a few years ago. Now we have ways of overcoming pain problems which are much better than the few means available to us even as recently as five years ago. This welcome change is the result of research carried out largely by pharmaceutical houses although other workers have contributed an important share as well.

Let us briefly consider the advances made in the fields of analgesic agents, tranquilizing agents and a variety of drugs that will induce sleep. Suppose we are confronted with an ordinary adult person who must undergo an operation for detached retina. It is desired to use general anesthesia. Accordingly, the patient is visited on the night before the day of the operation and is asked a few questions about previous experience with anesthetic agents, about sensitivity to drugs, and whether or not he smokes. If he smokes, he is asked not to smoke again until after the operation. Cessation of smoking at this time is very helpful in avoiding pulmonary irritation from smoke, with the resulting production of mucus which later can become inspissated to such extent that large pieces may even block the lumen of an intratracheal tube. If an excess of mucus is noted, however, a troche of calcium iodide and ephedrine given by mouth at bedtime and again the first thing in the morning sometimes will tend to liquefy these secretions and make it easier to aspirate them.

The patient is given 25 mg. of promethazine hydrochloride (phenergan hydrochloride) and 500 mg. of ethchlorvynol (placidyl) at the time for going to sleep, although other drugs such as glutethimide (doriden), methylprylon (noludar) and ethinamate (valmid) may be used alternately with the placidyl. Early the next morning, the patient is visited preoperatively and is asked whether he slept well. Some patients will say they slept all night and had to be awakened in the morning; others will say they slept intermittently and not too well. In either event, the answer should give the anesthesiologist some idea of how the patient is affected by drugs. As is well known, one extreme or another may take effect in a patient who otherwise seems to be in average condition. The nature of the patient's reactions to drugs again will be noted during the operation, the sequel to such observation being that he may require more or less than the average amount of the anesthetic agent.

The preliminary medication which we administer to the average patient, as we have described him, is 2 mg. of levorphan tartrate (levo-dromoran tartrate), which is an excellent drug for the control of pain. It is also said to produce less nausea and constipation than morphine. A dose of 0.5 mg. of levallorphan tartrate (lorfan tartrate) also is given so that respiration will be satisfactory. In addition, 25 mg. of phenergan hydrochloride is given. These three drugs can be put into one syringe and the injection can be made intramuscularly.

If the patient happened to be scheduled for an intranasal operation under local anesthesia, we would administer 30 mg. of mephentermine sulfate (wyamine) intramuscularly at the time the preliminary medication was given, to help support blood pressure. This measure is necessary because the patient will

From the Section of Anesthesiology, Mayo Clinic and Mayo Foundation, Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

Read at the meeting of the Upper Peninsula Medical Society, Marquette, Michigan, June 20, 1958.



THE AUTHOR
John S. Lundy, M.D.

be sitting up for the operation, and sometimes neurogenic shock will develop, the patient becoming cold, pale, and wet, as well as nauseated. He may vomit.

Sometimes the patient has a tendency toward this same reaction even though 30 mg. of wyamine was given at the time the preliminary medication was administered. In such circumstances, the intravenous administration of wyamine can be repeated, and it would be a rare patient, indeed, who did not respond to this measure.

Preliminary medication usually is given a half-hour before the patient is brought to the operating room. After the patient is put on the operating table, we insert a 20-gauge, 1¼-inch, short-beveled needle, usually in the vein in the antecubital fossa. Having selected one or two intratracheal tubes that seem satisfactory, we devise a plan which we will follow that includes the drugs to be used and the time that will be required to carry out the procedure. I usually inject 2 or 3 cc. of a 2.5 per cent solution of thiopental sodium (pentothal sodium) followed by 1 cc. of succinylcholine, and then 2 or 3 cc. more of pentothal sodium. If it is estimated that more succinylcholine will be needed, it is administered in doses of 0.5 cc., followed each time by 2 or 3 cc. of the solution of pentothal sodium. When muscle twitching starts, adhesive is applied to the upper teeth of the patient, and the anesthesiologist picks up the laryngoscope, opens the patient's mouth and inserts the blade of the instrument to lift up the tongue. The important point here is to institute intubation at the peak of the effect of the small doses of the drugs already mentioned. Use of the laryngoscope commonly is achieved by trying to insert it and to elevate the patient's tongue and epiglottis with it, to expose the vocal cords. I find that results are more satisfactory if I insert the laryngoscope and simply hold it as if it were a hook, grasping the jaw with the right hand so that I can elevate it with that hand and hang the epiglottis on the tip of the blade. In this way I avoid breaking teeth and traumatizing tissue with the tip of the blade of the laryngoscope.

I usually employ a Magill rubber intratracheal tube. On November 28, 1957, I decided to change the tip of the tube from a spoon shape to a shape resembling a pen point. This change allows insertion of the tube through the nose, avoiding polyps and deviations of the septum without causing nosebleed, unless the tube is too large for the nostril. This new tip will carry the tube from the nose into the nasopharynx with less effort than did the old tip, and it will separate the vocal cords and enter the larynx and trachea better than the old tip did. Once the tube is in place, an excellent airway is provided, which is very important with present-day methods of anesthesia which definitely depress respiration.

Once the tube has been inserted, it is connected to the gas machine and a 7-liter flow of nitrous oxide is used with a 3-liter flow of oxygen. Intermittently, more pentothal sodium may be used. Solution of curare is used instead of succinylcholine during the operation. At the end of the operation, it may be desirable for the patient to be almost returned to consciousness. This state, of course, can be achieved if the doses of drugs used during operation have been small.

When the hospital facilities are such that the patient would be much safer if his reflexes were sharpened, the following procedure can be used. For each 3 cc. of solution of curare given, I administer 1 cc. of edrophonium (tensilon chloride), and for each 100 mg. of pentothal sodium used, I administer intravenously 5 mg. of bemegride (megimide). The megimide usually will cause the patient to appear to be alert within fifty seconds to a minute. However, if he does not awaken, the dose of megimide can be repeated when three or four minutes have elapsed after the first dose.

There are those who do not admit that megimide is effective used in the manner described. Nonetheless, if megimide is administered to a patient who exhibits a characteristic lag between request and performance (a typical barbiturate effect) the demonstration will be convincing. Prior to the use of megimide, when the patient is asked to open his eyes, it may be possible to count to five or nine before he actually responds. After megimide has been administered, he will open his eyes as soon as the request is made. Another typical response is noted when a barbiturate anesthetic agent has been employed. When a patient thus affected is sufficiently awake to open the eyes on request, nystagmus commonly appears. This nystagmus may be noticeably modified if megimide is administered.

The foregoing remarks describe a considerable change in the methods of general anesthesia used previously. It is indeed a welcome change. In the associated field of control of painful conditions such as terminal carcinoma, and even prolonged chronic pain, definite progress has been made. For instance, when terminal carcinoma is at hand, the question of addiction to an anodyne is not important. Hence, doses of levo-dromoran tartrate large enough to relieve the pain can be prescribed and the patient's respiration can be protected by lorfan tartrate. I have

been using larger doses of lorfan tartrate than those recommended by the manufacturer, but I have been very well satisfied with the results.

This same program can be followed with the use of such drugs as morphine or dihydromorphinone hydrochloride (dilaudid hydrochloride), stimulating respiration with amiphenazole (daptazole). There are other drugs that might be used; all of them increase the activity recorded in electroencephalographic tracings since they stimulate the cortex of the brain. Two of these are wyamine and methyl-phenidylacetate hydrochloride (ritalin), and more such drugs are being developed, so the situation in the future may be much brighter than it is now.

In the presence of chronic pain without the factor of malignancy, when the problem of pain may persist for years, I consider it wise to provide for the comfort and the sleep of the patient at night. In such a problem, I usually start with the same medication that would be used for a surgical operation, meaning the giving of 25 mg. of phenergan hydrochloride and 500 mg. of placidyl or some sleep-producing drug. I believe that this measure is especially effective for patients who do not sleep well. I base my approach on the premise that if sleep is deep and restful, the patient will face the next day with renewed resolution and probably will be able to maintain himself without drugs, or at least, with the aid of such nonaddicting drugs as the synthetic anodynes (one is darvon and another is ethoheptazine citrate) and aspirin.

Some patients suffer from highly localized pain for which diagnostic block can be carried out to identify the pain pathway. Once such a pathway has been identified, the pain can be rendered nonfunctional for prolonged periods of temporary relief by the injection of a solution of 6 per cent phenol and water or absolute alcohol.

I hope to be able to interrupt the activity of peripheral nerves by means of electricity. If this can be done, the undesirable side effects of the accidental spilling of alcohol or phenol over nerves that are not involved in the pain pathway can be avoided.

Many other conditions which are painful come readily to mind, such as pain after thoracotomy, crushing injuries to the thorax and others. All these problems require the attention of someone interested in relief of pain, and I am confident that more intensive study will be directed at these medical enigmas, with some hope of success in the not too distant future. This is a conservative viewpoint, judged by the impressive changes and advances that have been made in anesthesiology since I entered this eminently useful field in 1910.

Bright Promise

There is a bright future ahead for the 4,000 babies who will be born in the United States with cleft lip and cleft palate during 1960.

This hopeful outlook is revealed by Eugene T. McDonald, Ed.D., director of the Speech and Hearing Clinic at the Pennsylvania State University. Dr. McDonald says that advances in surgery have made it possible to repair lips and make adequate functions possible in many palates.

Dental techniques have been developed for reconstructing by prosthetic means those palates which cannot be repaired surgically. Speech therapists today know how to help children with cleft palates develop good speech.

Furthermore, there are helpful sources for information on problems of cleft palate, as well as resources for treatment, including state and local Easter Seal societies, state crippled children's services, many public schools in metropolitan areas and the speech clinics at colleges and universities.

"Probably of greater importance than the child's cleft in determining his emotional adjustment is the way in which his parents work out their own feeling toward it. An understanding of these feelings—their beginning and how they grow—will help parents direct their feelings into wholesome channels," he says.

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

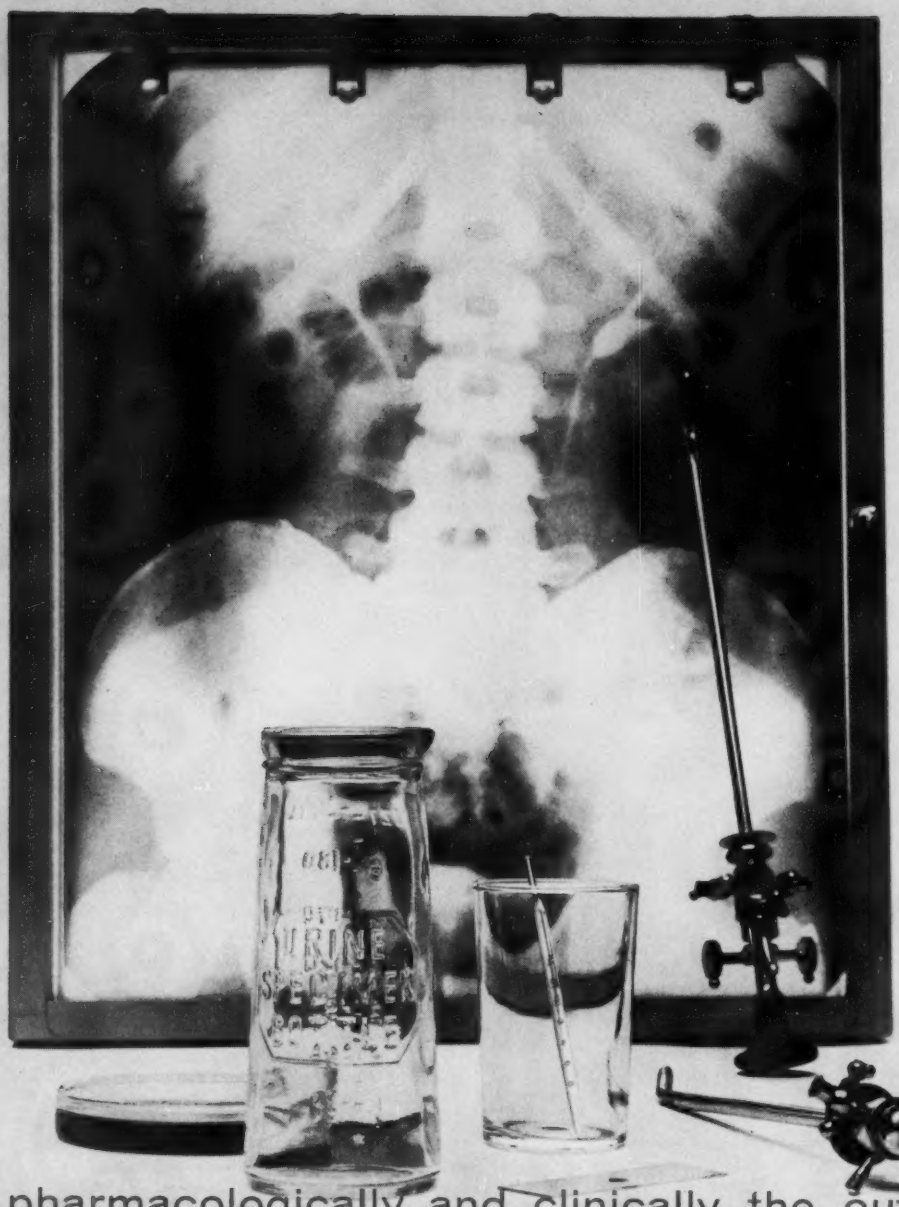
Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient



when sulfa is your plan of therapy...

pharmacologically and clinically the outstanding

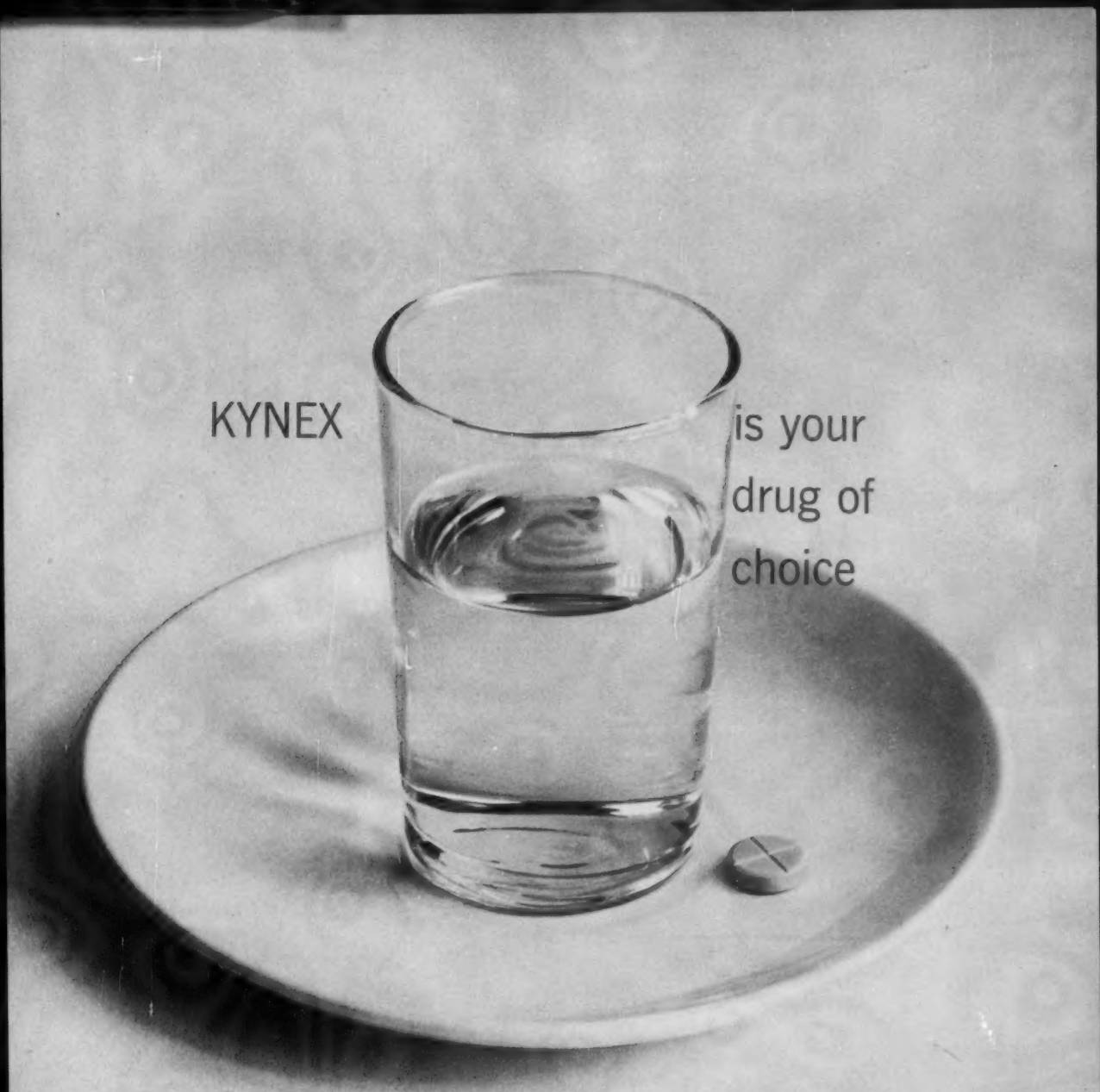
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed **TOTAL** side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa...

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



the clock strikes 2

and your ulcer patient sleeps undisturbed

daricon®

oxyphencyclimine HCl, 10 mg. tablets

2 tablets daily—'round-the-clock relief from ulcer and other GI disorders.

Additional information is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York.

Pfizer *Science for the world's well-being™*

Eye Wounds

M. D. Bentley, M.D.
Cadillac, Michigan

PARADOXICALLY, wars and injuries are not always exclusively destructive because a good deal of constructive information can be learned from treatment of these injuries. A good many medical war experiences can be turned to good use in the advancement of civilian practice of medicine. The purpose of this paper, then, is to pass on information gained by the author from the Korean war which might be put to use by practitioners in their daily practice. The general practitioner is often the first to see an injury, and this very important initial emergency chore becomes one of utmost importance. The eye is a small but extremely vital organ to the patient and, because of its delicate structure and function, it should be handled as such.

The surgical treatment of injuries to the eye and adnexa can best be divided into immediate and definitive treatment. Immediate treatment is mainly prophylactic and aimed at preventing further injury than that already caused by the initial trauma and to prevent, as far as possible, future complications. The injured eye should immediately be immobilized, a condition best obtained by patching both eyes and prescribing bed rest. An attempt should not be made to remove blood clots or foreign bodies without adequate anesthesia, good akinesia and proper lighting, for fear of converting a simple wound into one with extensive herniation of ocular contents. Atropine is advisable in most cases. Chemotherapy or antibiotic therapy should be instituted immediately. Tetanus antitoxin or a stimulating dose of tetanus toxoid should be given after any penetrating wound of the eye.

The advent of antibiotics and sulfa compounds has resulted in a marked decrease in infections of the eye following lacerations and injuries. It has been found that most antibiotics will not pass through the blood aqueous barrier of the eye in adequate amount; these even include penicillin and streptomycin. This may seem contradictory; however, the use of antibiotics will help protect extraocular structures from infection. Chloramphenicol (chloromycetin) taken orally will pass through the blood-aqueous barrier in sufficient quantities to help protect the globe, and is usually well tolerated. Cortisone and other steroids have been of great value in combating those inflammatory reactions which cause loss of transparency of ocular structures. They have also probably caused a decrease in the incidence of sympathetic ophthalmia and are certainly helpful in the treatment of this condition in case it does develop. If an ophthalmologist is available, he can worry about the long-term use of cortisone or any of the steroids.

The secondary treatment of ocular injuries falls more ideally within the realm of the ophthalmic surgeon. All of the precautionary measures just mentioned are continued. The eye should be carefully evaluated to avoid hurried and ill-considered treatment. In injuries to the eye alone, time is not a great factor, for there is no danger of shock or exanguinating hemorrhage. Infection is usually prevented by antibiotics. This permits careful evaluation of the extent of the injury and leads to a better judgment and skill in management.

The need for correct management is nowhere better exemplified than in injuries to the eyelid. Severe deformities requiring months of plastic surgery can be prevented by proper initial care. The skin of the eyelids and conjunctiva can be mobilized and shifted readily because it has an excellent blood supply and resists infection while remaining viable. Tarsorrhaphy, canthoplasty and sliding grafts can be used to approximate torn borders of the lids to each other, which, even in more serious injuries protects the eyeball and serves as a basis for future reconstructive surgery. If the torn edges are not joined, the remnants

THE AUTHOR
M. D. Bentley, M.D.



of the orbicularis muscle undergoes contracture, and what might have been originally half an eyelid, or even more, eventually becomes only a small tag of scar tissue laterally and medially, leaving a very extensive notch defect. If, on the other hand, the lid remnant had been ultilized properly, all deformities might have been prevented. The lid margin should be restored in all instances. If there is only a simple laceration, the wound edges can be sutured directly, or if tissue loss is extensive, utilization of sliding flaps can be made from the canthus.

Injuries of the lacrimal canalicular portion of the lower lid are difficult to manage because of difficulty in repairing the canaliculus and the medial canthal ligament.

Management of injuries to the eyeball itself require great judgment. The possibility of an intraocular foreign body must always be suspected. Careful examination should include x-ray studies and Berman localization before such wounds are treated.

Many factors influence the surgical judgment, among which are the type and size of the wound, location of the wound, presence or absence of foreign body, presence of lens injury, intraocular hemorrhage and others. Simple corneal wounds with no prolapse of tissue, if small, can be left untreated surgically. A smooth pressure dressing might lead to a smoother healing. Atropine or pilocarpine might be employed to retract the iris from the wound, depending on its location. Larger wounds should be closed either by direct corneal sutures, a conjunctival flap, or both. Scleral wounds are best closed by fine atraumatic silk sutures.

Lacerations of the cornea or sclera which are accompanied by intraocular damage are more difficult to manage. Iris prolapse, as a rule, should be excised, and the corneal wound closed as early as possible. However, if the prolapse is associated with severe lens injury, repair of iris prolapse should be delayed, even for as long as two or three days. This allows digestion of the lens, permitting linear extraction at the time of excision of the iris and repair of the wound.

The prognosis for wounds over the ciliary body must always be guarded. The outlook is best in clean wounds of the ciliary body where there has been little or no vitreous hemorrhage. A wound perpendicular to the limbus or cornealscleral junction results in less bleeding than a jagged wound, or one parallel with the limbus because of the nature of the blood supply of the ciliary body, where the vessels run from before backwards, parallel to each other. Large, jagged wounds with prolapse usually require enucleation. Enucleation, however, need not be hurried because infection is controlled quite readly by chemotherapy or antibiotics, and there is no danger of shock or hemorrhage. Operation should be deferred until all possibility of associated intracranial injury is excluded. This frequently necessitates x-ray studies of the skull. In more questionable cases, the indications for enucleation are not clear and the problem of sympathetic ophthalmia is of great gravity. The ophthalmologist gains some reassurance from knowing that this rarely, if ever, occurs less than two weeks after an injury. It is also emphasized that 80 per cent of the cases occur within three months after the injury. After the injury, until the third month, extreme care is urged. The most dangerous type of eye is one in which wound healing has been interfered with by incarceration of the iris, ciliary body, or lens material, or by retention of a foreign body within the eye. If such an eye developed subacute inflammation and begins to soften, it presents the most common exciting cause of sympathetic ophthalmia and should be removed. The only treatment of sympathetic ophthalmia is prevention. Indications of sympathetic ophthalmia beginning in the sympathetic eye are photophobia, lacrimations, slight pain, disturbance of accommodation and diminution of vision, aqueous flare, haziness of the cornea with keratic precipitates, cells in the retrolental space, deep congestion, irregular infiltrates of the iris, hazy vitreous, choroiditis and optic neuritis.

The management of intraocular foreign bodies is an extremely complex subject. Emphasis is placed on suspecting intraocular foreign bodies in all cases of penetrating injuries. When demonstrated, localization can be carried out by whatever means one prefers. The site of extraction is accomplished by either the anterior or posterior route. The posterior route should be elected if the foreign body is posterior to the lens, the anterior route if in the anterior chamber. When utilizing the posterior route, the incision is carried only to the uveal tract, the foreign body making its own opening through the choroid, or pars plana, as it is attracted to the magnet. If posterior to the pars plana, diathermy punctures should be made to prevent subsequent retinal detachment. The most feared complications are intraocular hemorrhage and retinal detachment.

Hemorrhage in the anterior chamber after corneal and iris lacerations is not as likely to cause secondary glaucoma as hyphemia in a blunt ocular injury. If the corneal laceration requires surgical repair, the blood is gently irrigated after the sutures are inserted, but before they are tied. If hyphemia occurs after surgi-

cal repair, it is treated like that resulting from a blunt injury. When bleeding of iris vessels follows a blunt injury to the eye, the blood at first mixes with the aqueous, but after a few hours it settles by gravity into the most dependent portion of the anterior chamber. It may remain unclotted and move about with the position of the head. It may be absorbed rapidly in a day or two, or it may form a firm black clot and absorb more slowly. Even with a small hyphemia, the eye usually remains hypotonic as the blood is absorbed. Hyphemia is ordinarily rapidly absorbed, unless there is continuous bleeding or unless clots form in the extravasated blood. If no iridodialysis, or tear of the iris root, accompanies the hyphemia, it is best to instill miotics, such as pilocarpine 1 per cent, bandage both eyes, restrict the patient's activities and gently measure his ocular tension each day. Atropine is usually contra-indicated because it seriously reduces the absorptive area of the iris and the peripheral iris roll blocks the filtration angle. The great danger after a blunt injury to the eye is not the immediate hemorrhage, but in the secondary hemorrhage which can occur one to five days after the initial blow, most often within twenty-four to thirty-six hours. Treatment of secondary hemorrhage consists of instilling miotics, continuation of the bandaging of both eyes, complete bed rest, and frequent tonometry. If the intraocular tension rises rapidly, surgical relief is demanded. Paracenteses, a corneal incision, should be done without delay. After an eye has been contused from a blunt force, such as a fist or elbow, the intraocular tension is very unstable, with periods of hypotony alternating with periods of hypertony. As a rule, this instability passes away without serious effect. Atropine is again contra-indicated, for if it is used, secondary glaucoma may occur from an obstructed angle. Eserine has been reported of value, but epinephine hydrochloride is the treatment of choice for traumatic glaucoma without hyphemia. Secondary glaucoma rarely develops without hyphemia.

In blunt injuries to the eye, occasionally scattered retinal hemorrhages are found and the vision may be nearly normal. This is because torn retinal vessels retract in the retina and their divided ends are closed by spastic contraction. However, twenty-four hours later, the vitreous may be filled with blood because this contraction ceases. It is important in the management of these cases to apply binocular bandages and require complete bed rest for several days after the injury. The macular region is particularly susceptible to injuries and contusions. This may result in a hole in the macula, the small area of acute vision, or cystoid degeneration may develop.

In the pathogenesis of a traumatic retinal detachment a hole may not be torn, or it may be torn and a detachment may not develop. The prognosis of traumatic retinal detachment for vision is generally poor. The technique of repair is similar to that of idiopathic detachment, and all breaks and tears must be located and sealed with diathermy coagulation.

It is realized that the information in this paper is somewhat sketchy. However, the aim has been to present some of the highlights in the treatment of ocular wounds and to present material which might help a worried general practitioner through some of his headaches in cases of ocular injuries.

Nursing Home Construction

A strong program of nursing home construction has been recommended by Russel A. Nelson, M.D., president of the American Hospital Association as one of the best methods for meeting the health care needs of the aged population.

"Nursing home care is central in the problem of care of the aged."

Much of the illness of old age is of a long-term type and new methods of caring for such illness are needed, he said. The general hospital, and its medical staff, is increasingly taking more responsibility for chronic illness, with research in degenerative diseases—so much a part of aging—increasing. However, the general hospital cannot handle the aged's health care alone.

"It may be," Dr. Nelson continued, "that there is need for a strong program of federal financial assistance in the building of superior non-profit nursing home facilities, with special emphasis on non-profit nursing homes incorporated into or affiliated with general hospitals."

Oral Cholecystography

Using Prior Fat Meal and Increased Telepaque Dosage

Philip W. Dorsey, M.D.
John L. Anderson, M.D.
Flint, Michigan

THIS STUDY was conducted to ascertain the effect on cholecystographic visualization of the gallbladder of two different variables, particularly on patients with non-visualization with the usual routine examination:

1. The withholding or the administration of a fat stimulus prior to the oral ingestion of Telepaque.
2. The use of Telepaque in the usual single dose of 3 gm. or the double dose of 6 gm. (twelve tablets).

Method Employed

An oral cholecystographic study of 208 cases was done. The examination was varied (Table I) on each of five hospital floors and x-ray films were obtained in the usual manner. All patients received either a fat-free diet or a fat stimulus prior to a single dose of Telepaque (six tablets, 3 gm.). If nonvisualization occurred, some of the patients were immediately given a fat meal stimulus (cholex) followed that evening by a non-fat meal and then either a single 3 gm. or a double 6 gm. dose of Telepaque. Other patients in which nonvisualization occurred received a single or double dose of Telepaque without any fat between examinations.

After cholecystography it is very often assumed that the nonvisualized gallbladder implies a diseased gallbladder.[1-7] In general that is true in 85 per cent of the cases. However, there are other causes of nonvisualization as shown in Table I. It is important to confirm these radiologic findings to eliminate these possibilities to be sure that these are not causing the nonvisualization, since the patient's status will not be improved by surgery under the latter set of circumstances. Since nonvisualization due to biliary stasis may be purely a physiologic condition, surgery would be contraindicated without the presence of pathology in the gallbladder.

Extra biliary and biliary causes of nonvisualization of the gallbladder are listed in Table II.

Of the extra biliary causes, congenital absence of the gallbladder needs no further comment. Failure to take the radiopaque medium may occasionally occur. For example, the nurse may misinterpret orders for a gastrointestinal series and fail to give the patient the tablets, or the patient is not made aware of the association between the tablet ingestion and gallbladder opacification and presents himself for examination without this necessary preliminary.

TABLE I. CAUSES FOR NONVISUALIZED GALLBLADDERS

Extra-Biliary Causes
1. Congenital absence
2. Failure to take radiopaque medium
3. Radiopaque non-absorption due to diarrhea, vomiting, or pyloric obstruction
4. Tumors or masses obstructing cystic or biliary ducts
5. Faulty liver function

Biliary Causes
6. Diseased gall bladder
7. Biliary stasis

Radiopaque nonabsorption due to diarrhea, vomiting, or pyloric obstruction occasionally occurs. All nonvisualized patients are routinely questioned as to whether they had nausea, vomiting, or diarrhea following their dye ingestion. Since Telepaque is absorbed from the small intestine, vomiting does not give the radiopaque an opportunity to be absorbed; whereas, during diarrhea, the radiopaque medium may pass too rapidly through the small bowel to allow absorption. A case of bowel obstruction preventing radiopaque absorption was demonstrated dramatically recently when the first gallbladder film showed nonvisualization, but on closer inspection fine Telepaque particles could be seen still distributed throughout the stomach. A gastrointestinal series was recommended and the patient was found to have an obstructing tumor in the pancreatic head.

Tumors or masses obstructing the cystic or biliary ducts such as carcinoma of the duodenum, pancreas, or metastatic enlarged nodes can produce an obstruction to the passage of Telepaque into the small bowel. Thus, even though Telepaque is absorbed from the small intestine, it does not get into the gallbladder if the biliary or cystic ducts are obstructed.

TABLE II. GALL BLADDER VISUALIZATION WITH VARYING TECHNICS OF PRIOR FAT MEAL AND TELEPAQUE DOSAGE

Hospital Group	Number of Patients	Initial Preparation		Gall Bladder Initially				Repeat Preparation		Non-Visualized Gall Bladder Visualized c		Total Gall Bladders Visualized	
		Prior Fat Meal	Telepaque Dosage 6 Tabs. (3 Gm.)	Visualized Patients	Per Cent	Non-Visualized	Per Cent	Prior Fat Meal	Telepaque Dosage	Repeat Examinations	Per Cent	Patients	Per Cent
1st floor	49	No	Single	37	76%	12	24%	Yes	Double 12 tabs. (6 Gm.)	8/11*	73%	45/49	92%
2nd floor	68	Yes	Single	52	76%	16	24%	No	Double	2/12*	17%	54/68	78%
3rd floor	20	No	Single	13	65%	7	35%	No	Double	3/7	43%	16/20	80%
5th floor	32	No	Single	22	69%	10	31%	Yes	Single	4/10	40%	26/32	81%
6th floor	39	Yes	Single	33	85%	6	15%	No	Single	0/5*	0%	33/39	85%
	208 Total patients treated.												

*Repeat examinations cancelled; 1 each on 1st and 6th floors, 4 on 2nd.

Faulty liver function may prevent the normal metabolism of Telepaque which is selectively excreted in conjugated form with the bile salts, and if these salts are being improperly formed the gallbladder may not be visualized.

A diseased gallbladder is the most common cause of nonvisualization, constituting approximately 85 per cent of the cases of cholecystitis, and this is what most physicians assume is the primary cause of nonvisualization.

Biliary stasis due to a physiological lack of normal stimuli may occur in patients who for one reason or another have restricted fats in their diet for varying periods of time. The gallbladder normally concentrates the bile with the passage of time. Many patients who have been on a low-fat diet are found to have gallbladder bile the consistency of jelly, whereas, the specific gravity of freshly produced bile is lower than that of bile within the gallbladder. If the patient has been on a low-fat diet for a long time, the gallbladder has not been contracting and emptying regularly so that biliary stasis mechanically prevents the radiopaque medium from being absorbed and concentrated in the gallbladder. Thus, if a patient with physiological stasis is maintained on a low-fat diet and nonvisualization is reported from cholecystography, unnecessary surgery may be performed. Perhaps some of these patients should be given a normal diet including fat preceding the cholecystographic examination. In a situation where fats have been withheld from the patient for prolonged periods and nonvisualization occurs, administration of a double dose of Telepaque has also been utilized (Table II).

Results

First, the effect of fat preceding the initial Telepaque dose was tested by comparing the average of the first, third, and fifth floors with the second and sixth floors as shown in Table II. The average visualization with no fat in the initial preparation was approximately 70 per cent (first, third and fifth floors); where fat was used with the initial preparation, it was approximately 80 per cent (second and sixth floors). Thus a fat meal prior to administration of oral radiopaque medium resulted in 10 per cent higher visualization of gall bladders in cholecystography.

Second, the effect of administering a double dose of Telepaque was compared to the single dose. On the first floor versus the fifth, the initial preparation was the same. On the repeat examination, the only difference between the two groups was a double dose preceded by fat on the first floor, and a single dose preceded by fat on the fifth floor. Seventy-three per cent of nonvisualized gall bladders visualized following a double dose of Telepaque preceded by fat as compared with 40 per cent visualization using a single dose preceded by fat. One patient was dropped because it was a surgical emergency which could not wait for repeat examination, so that eight out of eleven, or 73 per cent, were visualized as shown in Table II. The same thing could be determined, that is, the effect of administering a double dose of Tele-

paque over the recommended single dose by comparing the second floor with the sixth. In both cases the initial preparation was the same, the only difference being the single or double dose on the repeat examination. Seventeen per cent of the nonvisualized gallbladders visualized with a double dose not preceded by fat, as compared with 0 per cent visualization using a single dose not preceded by fat. These data show that a double dose of Telepaque does increase the degree of visualization and that it is also markedly higher if preceded by a fat meal.

Third, the effect of giving fat with the initial examination was compared with giving fat at the time of the repeat gall bladder examination—fifth *versus* sixth floor. No fat with the initial examination (fifth floor) produced 69 per cent visualization. Fat with the initial examination (sixth floor) produced 85 per cent visualization. If fat is given with the repeat examination, the total visualization is 81 per cent. On the sixth floor the reason for the zero visualization is that all of the cases which were going to respond had already done so with the initial preparation using fat, and repeating this with no fat on the repeat single dose study actually accomplished nothing. Whereas

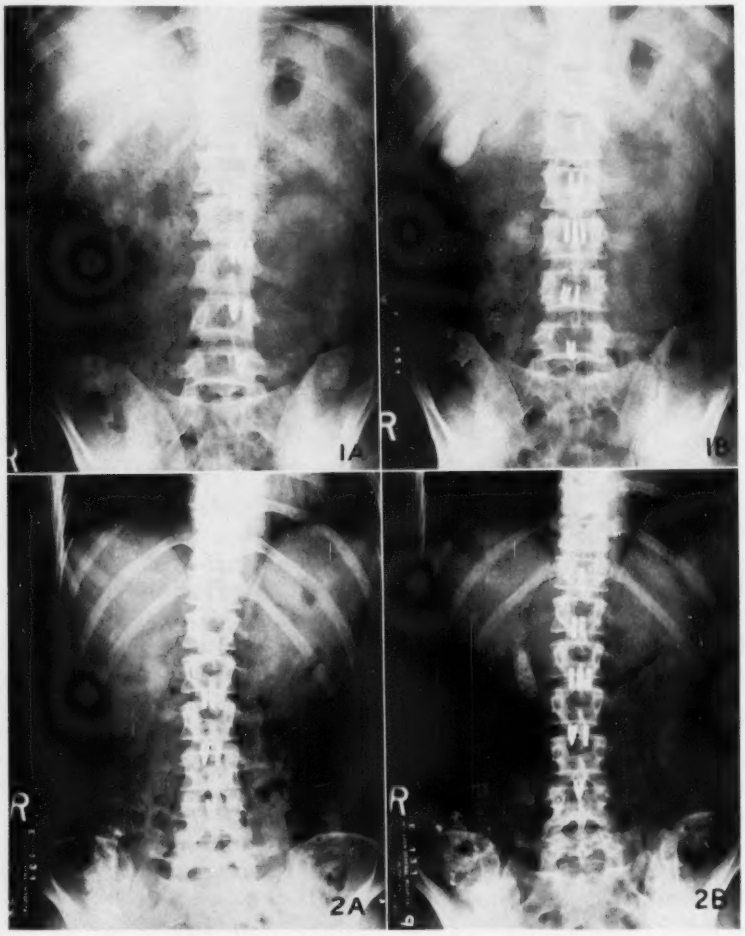


Fig. 1(a). Non-visualization following routine single dose of Telepaque. (b). Fat meal prior to double dose of Telepaque. Well visualized completely normal gallbladder.

Fig. 2 (a). Non-visualization following routine single dose of Telepaque. (b). Fat meal prior to double dose of Telepaque. Moderate visualization of gallbladder showing many cholesterol stones.

on the fifth floor there was no fat preparation, and again, the effect of fat is quite apparent—40 per cent of the nonvisualized gallbladders did visualize. Fat enhances the number of visualized gallbladders, but it makes little difference whether it is administered prior to the initial or repeat Telepaque dosage.

X-rays of two cases of nonvisualization of the gallbladder due to biliary stasis are shown in Figures 1 and 2.

Illustrative Cases

Non-visualization due to biliary stasis:

Case 1.—(Fig. 1a) This patient had a non-visualized gallbladder following a routine dose of Telepaque (3 gm.). The next day a fat meal was given prior to a double dose of Telepaque (6 gm.) and this showed a completely normal gallbladder (Fig. 1b).

Case 2.—(Fig. 2a) This patient had a non-visualized gallbladder after a single dose of Telepaque. The next day a fat stimulus followed by a double dose of Telepaque showed moderate visualization of a gallbladder with many cholesterol stones. (Fig. 2b).

Non-visualization due to non-absorption of Telepaque (pyloric obstruction):

Case 3.—This patient showed a non-visualized gallbladder after routine single dose of Telepaque, but this study was of no significance concerning the status of the gallbladder since all of the radiopaque was seen within the stomach. A gastrointestinal examination revealed complete pyloric obstruction which was demonstrated at surgery to be caused by carcinoma of the pancreas with invasion of the pyloric canal.

Summary and Conclusions

Although the usual cause for nonvisualization of the gall bladder is chronic cholecystitis, stones or other pathological conditions, other factors may also be important.

Of particular importance is the physiological condition of biliary stasis due to lack of the normal stimulus of fat in the diet which the patient has omitted for one reason or another. Therefore, with biliary stasis the administration of a fat stimulus will allow the gall bladder to contract and then allow visualization with the radiopaque. In these latter patients, needless surgery may be avoided.

Cholecystographic examinations were made ten to twelve hours after oral doses of four to six tablets of Telepaque to 208 patients who had either been on a fat-free diet or received a fat meal prior to the administration of the radiopaque substance.

These studies showed that the number of visualized gall bladders is increased appreciably by administering a fat stimulus prior to ingestion of Telepaque. The number of visualized gall bladders is further enhanced if the repeat dose of Telepaque is double the initial dose.

It is suggested that, since some patients do not tolerate fats, the fat stimulus be withheld and administered only if the gall bladder fails to visualize initially. It is also suggested that the double dose be withheld for the repeat examination so that such possible causes of nonvisualization as diarrhea and vomiting may be eliminated. Also for economic reasons, since three of four cases are well visualized with the single dose of Telepaque, the double dose is recommended routinely only for the repeat examination.

Acknowledgments

Miss Tice, and staff of the X-ray Department of the McLaren General Hospital were helpful in the above studies.

References

1. Whitaker, L. R.: The use of the fat-rich meal in cholecystography. Surg., Gynec. & Obst., 100:473, 1955.
2. Cimmino, C. V.: Experiences with the upright fluoroscopic spot-film examination of the gall bladder. Radiology, 67:74, 1956.
3. Dietz, M. W., and Litton, L. D.: Syllabus of cholecystography. GP 14:109, 1956.
4. Shehadi, W. H.: Roentgen studies of the biliary tract—an evaluation of recent contributions. Am. J. Gastroenterol., 28:236, 1957.
5. Lake, F. D.: The nonvisualizing and poorly visualizing gall bladder. Am. J. Roentgenol., 78:617, Oct., 1957.
6. Moeller, H. C., and Texter, E. C., Jr.: Problems in the management of biliary tract disease. Am. J. Digest. Dis., 2:521, 1957.
7. Cuniff, C. L., Dolan, M. A., and Leevy, C. M.: Cholecystography in portal cirrhosis without jaundice. Gastroenterology, 25:557, 1953.

206 Flint Medical Arts Bldg.
Flint 4, Michigan

Strip Test for Phenylketonuria

A simple dip-and-read strip test for detection of phenylketonuria offering a greater degree of accuracy than the conventional liquid ferric chloride test is described in *Clinical Chemistry* (5:5, 405-413, October, 1959). These vital tests, generally conducted on the urine of babies, can signal the need for corrective therapy to prevent mental retardation.

Professional Liability Insurance

C. E. Umphrey, M.D.
Detroit, Michigan

LET ME START this article with a challenge. You don't know whether your coverage is adequate or not. You actually do not know the company you are insured with. Perhaps you can recall the name, but do you know anything of its holdings or the manner in which it handles claims? Have you read the fine print? Has the company a well-deserved reputation?

A physician must be aware of the limitations and exclusions of his policy. Purchasing a policy on the basis of price alone is a grave error. Is your Insurance Company located out of State, and if so is it subject to the laws of the state of Michigan? How much insurance should you carry? Does your specialty carry a higher liability factor?

We could be much more constructive if from this point on we would outline all the factors concerned in good professional liability insurance. The first, and by all means, greatest responsibility rests entirely with the medical profession. Our pre- and postgraduate teaching in professional liability has been critically inadequate. The present thinking would indicate courses in the junior year with a review as seniors. This should be followed by a comprehensive analytical study when the doctor joins his county medical society. Every doctor of medicine must know his responsibilities to the patient. He also must know the definite procedures that he must take if suit is brought against him. *If liability exists the patient is entitled to compensation.* That is the purpose of professional liability insurance. If no liability exists, we should be assured that the very best services will be mustered to defeat such despicable practices. We believe this is the only way we can reduce dishonest claims to a minimum.

Having recognized our own responsibilities we should review the prerequisites of good liability insurance:

1. Insurance must be available to all members in good standing.

2. The MSMS Committee to study insurance plans can approve for the memberships on such items as cost, financial strength of the insurance company, limitation clauses, and efficiency as to handling of claims.

3. Insurance must be available to cover individual requirements, such as those of the specialties.

4. An insuring member should be assured that a "Mutual" company does not expose the doctor to assessments.

5. The insurance company's and the doctor's rights to cancel the policy should be carefully reviewed.

6. All out of state companies should conform with the laws governing insurance in the state of Michigan.

7. Although group policies are illegal in this state, individual policies can be prepared with the cooperation of the MSMS which would permit a closer exchange of facilities and compensatory reduction in cost if the expense of protection in this state proved to be low. One company has made such an offer.

8. Your insurance company should meet the requirements of the National Association of Insurance Commissioners.

9. Your insurance company should join with the MSMS in offering every possible aid in the teaching program of our two state universities.

10. Approved insurance companies could be of great help in giving short trend progress reports at our general medical meetings.

Your committee was delegated the duty of analyzing the present trends in malpractice claims in this country. This we have faithfully done, and various recommendations have been made. So far Michigan has escaped comparatively unscathed. The storm is brewing, however, and to ignore it would be turning our back on all the trends of the day. The chairman

Dr. Umphrey is Chairman of the Committee to Review the Problem of Professional Liability.



THE AUTHOR
C. E. Umphrey, M.D.

is grateful to the members of the committee, and the doctor members are especially grateful to those of the legal profession for their most valuable advice in this difficult problem. Finally, we wish to offer any aid required of us in the new teaching program of our two universities.

Situation Elsewhere

A comprehensive report on the malpractice situation in California was recently made to the committee by one of its members, Mr. George H. Cary, and the committee has recommended that this report be published in JMSMS at an early date.

The committee also wishes to call attention to a recent and most significant contribution to the law on the subject of professional liability, co-authored by one of the members of the committee. This is "The Law of Medical Practice" written by Burke Shartel and Marcus L. Plant, each of whom is a professor of law on the faculty of the University of Michigan. This fine work is published by Charles C Thomas of Springfield, Illinois, and is highly recommended to the profession.

In conclusion, it is recommended to The Council that although the further study of group liability insurance has been committed to the Society's Committee on Insurance, this or a similar committee could continue to be of real value to the Society in (a) watching and reporting on trends and changes in the law relating to professional liability, and (b) the promotion of professional liability prevention measures through education both in the medical schools and among the profession generally.

What's Good For a Cold?

All around the Northern Hemisphere this week, with winter's assault of colds and influenza near its seasonal peak, millions of sniffling, hacking customers went to the corner drugstore to shop for what they hoped would be a cure, or at least a palliative, for their suffering. Whether they called their complaint a cold or catarrh, *die Grippe** or flu, the answer was the same: for none of these illnesses caused by viruses does medicine have a cure. The best that any victim can expect is the relief of some immediate symptoms and unimpeded recovery from the original viral infection before a secondary bacterial infection can cause complications (best known and gravest: pneumonia).

Despite the fact that people swallow an infinite variety of pills, tablets, capsules and syrups, medical scientists are still far from agreed as to which of them is best—or even whether any treatment for uncomplicated viral infections is desirable. A runny nose is an uncomfortable and socially embarrassing symptom, but the increased fluid secretion by the nasal mucosa is, some experts believe, one of the body's defenses against viral invasion. Drying up the mucosa (usually with antihistamines), they say, may simply prolong the battle. The fever that results from many virus infections is also widely regarded as a major defense mechanism, might best be allowed to run its course.

Nature Does Its Best. No physician has yet had a good word to say for the headache and muscle pains of grippe or flu, so mild, painkilling drugs win ready approval. Trouble is that the commonest of these are aspirin and related salicylates—and these also drop the body temperature. Therefore even they may do harm as well as good.

The traditionally most potent fever fighter has been quinine. Thanks to its long and distinguished history as the only effective weapon against the recurrent fevers of malaria, quinine is still highly regarded in Europe and among many older Americans (especially in the recently malarial South) for treating fevers. Last week, in Munich's *Medizinische Wochenschrift*, Dr. Wolfgang-Dietrich Müller damned quinine with the results of a study on thousands of patients in Bielefeld. Among those who took quinine pills at the first sniffle, Asian flu was five to ten times as common as among those who let nature do its best. Quinine, he suggested, may actually be harmful by blocking the body's defense reactions. (In any case, quinine's effect in malaria is against the parasites themselves, so it is ineffective against fevers from other causes.)

Aspirin & Sophistication. In the U.S., such old favorites as Hill's Cascara Quinine (Whitehall Pharmacal Co.) and Bromo Quinine (Grove Laboratories, Inc.) retain a faithful but shrinking following. They have been crowded to the side of druggists' counters by supposedly more sophisticated products of the antibiotic, antihistamine age. A current favorite is Coricidin (Schering Corp.), combining APC with a small enough dose of the anti-histamine Chlor Trimeton be sold without prescription. If the customer does not know what he wants, many druggists recommend this. Competitive runners-up: Dristan (Whitehall) and Super-Anahist (Anahist Research Laboratories). Ascorbic acid (vitamin C) has become popular, though its value is largely unproved.

Customers often ask for antibiotics. Instead of explaining that no antibiotic does any good against virus infections, druggists usually tell them they need a prescription. (Virtually the only antibiotic preparations not on prescription are tablets containing small amounts for sore throats.) They then generally recommend aspirin in one of the proprietary versions of APC on which there is a fat price markup. Though the medical benefits of aspirin are not easily measured, most doctors agree that it does some good, somehow. —*Time*, February 22, 1960.

*In France, *la grippe* originally meant only influenza; Germany's *die Grippe* covers various flulike illnesses; in the U.S., "grippe" is often used for infections intermediate in severity between the common cold and flu.

California Malpractice

George H. Cary, LL.B.
Detroit, Michigan

ACTING under sanction of this committee (Medical-Professional liability), it was my pleasure to discuss the California malpractice situation with several prominent defense counsel at Los Angeles and San Francisco. The purpose of this study was first to determine from the lawyer's viewpoint the real proportions of this admittedly serious situation; second, what is being done to control and improve the matter. Factors of time and my good wife's belief we were on a vacation limited my study of the problem.

Fortunately, the day we arrived at Los Angeles, a luncheon was arranged by my brother-in-law, Don Sessions, vice president in charge of the Los Angeles district for American Insurance Company, with Mr. Harry Parker, senior partner in a leading defense firm, Parker, Stansbury, Reese and McGee. Malpractice is a limited part of their work and is handled principally out of their Orange County office by Mr. Reese. Mr. Parker stated the situation was serious. In fact, he commented, "It was often hard to get full co-operation from doctors since it was no longer unusual for a doctor to be sued for malpractice." This large firm handles cases for insurance companies that write doctors on an individual policy basis. Hence, the remarks seem more important later in contrast to the co-operation from the medical societies given defense counsel handling cases under various group insurance plans.

We found that a substantial part of the Los Angeles doctors obtain malpractice insurance under a group plan handled by a particular insurance agency for the Los Angeles Medical Society. This has been developed over a period of years and was first put into operation under the guidance of the late Dr. Reagan, author of "*Doctor and Patient and the Law.*" The firm of Reed, Calloway, Kirtland and Packard handled the legal work of this agency and a luncheon was arranged later in the week with Mr. Kirtland.

Our time was limited as he was engaged in trial with an important case that had been in progress for over a week. Plaintiff's attorneys were attempting to extend *res ipsa loquitur*, recognized by the California Supreme Court in a broad way, to include an infection following an operation solely based on the theory medicine is now an exact science and modern technique does not permit an infection to follow an operation, except as the result of negligence. The California Supreme Court has accepted *res ipsa* in surgical accident and most injection cases, as well as other situations, but Mr. Kirtland did not expect the appellate court to extend the doctrine to this abdominal infection situation.

Briefly stated, the plan of this agency, with the active coordinated and supervised support of the Los Angeles Medical Society, was invaluable in his opinion to the lawyer handling the defense of these cases. Investigation was complete and handled by trained investigators working solely in this specialized field. Committee medical society handling of the case was not used in the same manner I found in the San Francisco area, but Mr. Kirtland stressed the fact that practically any doctor in the society could be called in for a group meeting to study and testify if necessary. It was interesting to find the meeting in preparation for trial often included dinner and cocktails at the Los Angeles Athletic Club, and in some cases a member of the society supposed to favor the plaintiff might be asked to attend and explain his professional viewpoint to his colleagues.

After lunch I met Mr. Sidney Moss and Mr. Gerold Dunn of Moss, Lyon and Dunn. Graciously giving me most of the afternoon, I was referred by Mr. Dunn to an excellent article in the July, 1957 issue of the Stanford Law Review entitled "The California Malpractice Controversy."

Surprisingly, I found malpractice cases in respect to the size of verdicts were more of a problem in staid old San Francisco than Los Angeles. One would expect sprawling Los Angeles, with its metropolitan district approaching ten million and in many ways resembling Detroit, to be the seat of the trouble. Perhaps Marvin Belli, who is reported to represent the left wing of the plaintiff association NACCA and

practices in San Francisco, may be a factor, but California attorneys do not care to give him this recognition.

Mr. Moss said there were more attorneys taking malpractice cases, and in consequence more cases being filed to harass the doctors. As usual, a large percentage are without merit. Most of these cases are referred to a few trial counsel specializing in the plaintiff malpractice case. An obvious solution is to refuse nuisance value, as it will be impossible for these trial counsel to handle cases without merit, often taking a week or more of trial work if defense counsel force them to try out a large number of their referrals.

Actual figures supplied by Mr. Moss for Los Angeles County will hold substantially the same for the entire area and indicate for 1958, 10,000 personal injury cases were filed, and about 1,000 tried. Of these, 846 reached verdict, with 58 per cent no cause for action, 6 per cent hung and 35 per cent plaintiff. Only 17 (2 per cent) of these cases were malpractice, and the verdicts for plaintiffs totaled $163,375, with a high verdict of $78,000 and a low verdict of $2,100. It seems from these figures that the Los Angeles verdicts are still under reasonable control by defense counsel. However, the increase in suits filed is still a problem for the medical profession.

At San Francisco, Mr. Edward Bragg, claims manager for American Insurance Co., made an appointment for me to talk with Mr. Hoge of Lamb & Hoge, specializing in defense work, and a most fortunate luncheon meeting with Mr. Thomas Hadfield, general manager in charge of the Malpractice Division of American Mutual Liability Insurance Co., also his able assistant, Mr. Callaghan. According to Mr. Hoge, the situation in San Francisco is serious. Suits have not only increased in number, but verdicts often range from $50,000 to $250,000. Various factors are cited, high income and fees of doctors, lack of house calls and personal contact with patients, perhaps in part due to the social trend, including surgical and hospital insurance. Verdicts in San Francisco are high in other personal injury cases, and little credit is given Belli or other plaintiff's attorneys. It was interesting to find a large malpractice settlement was made in a case against Belli arising out of a malpractice case he was alleged to have improperly handled.

American Mutual Liability Insurance Co. write their sole special doctor's policy for the San Francisco area. This includes twenty-three county medical societies, and Mr. Hadfield speaks from seventeen years' experience with this problem. The insurance policy is tailor made to suit the doctor's needs and the coverage is high. The cost is about double our rates, but it gives broad protection in an area of high and numerous verdicts. Their program eliminates the nuisance settlement and forces plaintiff's counsel often to dismiss the suit rather than gamble the expense of trial and appeal. Substantial per diem jury fees give defense counsel an advantage we do not have in Michigan.

Under the plan, each participating county medical society has a committee that includes the insurance representative or lawyer, doctors, ministers and even laymen who review the assigned case to decide whether it has any merit or should be defended. Publicity has been given to the arrangement and many patients claiming a grievance have their case reviewed either with or without employing counsel. This gives the doctor and the insurance company the double advantage of an early settlement without publicity or added fees in cases of merit, and it puts them on notice of potential suit in claims without merit.

All the assistance and co-operation of the Los Angeles Medical Society plan is available. It is felt these committees are restoring public confidence in the integrity of the medical profession. This committee reviews only claims relating to malpractice and makes an impartial decision on the merits. Complaints relating to fees or the conduct of a doctor are handled by a separate committee.

It is the purpose of this arrangement to provide a basis for the quick settlement by the insurance carrier of any claim with merit and to require the carrier to defend vigorously all other claims. It should be noted this may place a burden on defense counsel. Recently the committee had decided a case was without merit, but the doctor, with only $50,000 limits, wanted his case settled, and the jury returned a verdict of $90,000.

In Los Angeles, I had been told to read the case of *Salgo v. Stanford University*, decided in October, 1957, as this case would bring me up-to-date on the subject of *res ipsa loquitur*. It was interesting to find Mr. Hadfield's company spent approximately $35,000 in the defense of this $250,000 judgment. The term vigorous defense takes on some meaning. It is doubtful whether a company writing scattered individual policies would do this, but I believe it was well worth the investment after reviewing the important modern points of law established in this case for California. (Shartel & Plant, "*The Law of Medical Practice*," Sec. 3.23, p. 144).

What has this to do with Michigan? It would appear under the present trend of our Supreme Court, as evidenced in *Higden v. Carlsbach*, and other decisions, that we are entering a new era in malpractice similar to the California problem. The doctrine of *res ipsa loquitur* has been adopted in Michigan in the *Higden* case, and it is my personal opinion that the situation in the next five years will resemble Los Angeles, but not San Francisco. There is no reason to believe we will have many six figure verdicts from Michigan juries.

Attorneys have handled these cases for the last forty years with limited coverage written as a rule for the individual physician under this general formula:

1. Most attorneys refuse to take malpractice, or at least it has to be an extremely clear case.

2. Ninety per cent of the cases with merit can probably be defended as a matter of law due to the inability of the plaintiff to get expert testimony from the same school and in the same locality.

3. If a question of fact is raised, the jury will resolve any doubt in favor of the overworked doctor, who does most of his work for charity.

4. If the case has some merit and is not dismissed before trial, it can be settled for the special damages and a small attorney's fee, or practically nuisance value.

These old concepts will have to be severely modified. Cases of merit should be settled for their fair value and other cases defended without nuisance payment; otherwise inroads on the time and reputation of the medical profession can hardly be avoided. Defense counsel must work vigorously to establish the new rules and boundaries of liability in a battle that will become in many more cases a decision for the triers of the facts. Decisions, such as the *Salgo* case in California, setting the limits and defining the instructions for the jury, will become extremely important.

It is fortunate that Professor Shartel and Plant of the University of Michigan law school have just published a new text, "*The Law of Medical Practice.*" This new work brings us up-to-date on the limited decisions in Michigan, and clearly points out the decisions in California and other states that may influence future Michigan decisions regarding malpractice.

It was published last month by Charles C Thomas at Bannerstone House, 301-327 E. Lawrence Ave., Springfield, Illinois, and has been simultaneously published in Canada and England. It is primarily a book for the doctor and covers every facet of professional legal liability in addition to malpractice.

Retrolental Fibroplasia

A few months ago, the Department of Ophthalmology of Mercy Hospital, Cadillac, was requested to bring up to date the regulations and ideas regarding the use of oxygen in premature babies, with special reference to retrolental fibroplasia. A poster was prepared, printed and posted. M. D. Bentley, M.D., Cadillac, prepared the poster, "Oxygen Use in Infant Care," and offers the use of it to any who may wish to use it.

OXYGEN USE IN INFANT CARE

Controlled study shows conclusively that the length of time the premature infant is kept in an oxygen-enriched environment is THE important factor in the production of retrolental fibroplasia.

Intelligent use of oxygen can be the means of saving the lives of hypoxic babies. It would be unwise to arbitrarily deny adequate oxygen to those babies because of possible injury to the eyes of some.

"There is *no* concentration of oxygen in excess of that in air that is not associated with risk of retrolental fibroplasia.

"Infants of multiple birth appear to be significantly more susceptible to retrolental fibroplasia than infants of single birth.

"The following recommendations are made:

"1. Oxygen should be prescribed only on medical order (except in emergency).

"2. Oxygen should not be administered routinely.

"3. The length of time a premature infant, particularly an infant of multiple birth, is kept in an environment containing oxygen in excess of that of air should be kept to an absolute minimum, consistent with the clinical indications of anoxia.

"4. When oxygen therapy is clearly required, it should be prescribed on an hourly basis and the concentration should be as low as possible.

"5. Ordinarily, the indications for supplemental oxygen are general cyanosis and dyspnea. The urgency of treating these symptoms must rest with the physician's clinical judgment.

"6. Oxygen concentration must be determined by means of an oxygen analyzer every four hours or oftener if necessary.

"7. Infants of four pounds or over are less likely to acquire retrolental fibroplasia. However, indescriminate use of oxygen in any infant, regardless of weight, carries the possibilities of producing retrolental fibroplasia.

(Prepared by the Department of Ophthalmology, Mercy Hospital, Cadillac, Michigan)

L. Fernald Foster, M.D.

The March number of THE JOURNAL of the Michigan State Medical Society is respectfully dedicated to the memory of L. Fernald Foster who served the Michigan State Medical Society, the medical profession of Michigan and the people of Michigan with his almost every waking hour for thirty-nine years.

On the cover we are reproducing the picture which he probably considered his best. It was a charcoal drawing done by Mr. Coppin, renowned portrait painter in Detroit. The original hangs in the gallery of the Michigan Medical Service building in Detroit.

Doctor Foster inscribed his name upon the records of Michigan Medicine and of the Michigan State Medical Society indelibly. He was a born secretary with the keen knowledge and appreciation of the thousands of details which go to make an efficient and accomplished secretary. The Bay County Medical Society selected him as secretary during his first year in practice in Bay City and he continued in that position for thirty-nine years taking out only one year during which he served as President.

In 1936, the Council of the Michigan State Medical Society selected him as layman, medical secretary, because in addition to the active secretary and administrative director, the need was for a physician who could carry the message of medical organization, medical ambitions, and medical philosophy to the membership in a direct personal contact—as well as from a secretarial office.

Fern Foster liked people. He was a keen, well trained, and most efficient pediatrician. He knew doctors and their problems from contacts over many years. He accepted the secretarial job as one needing to be done and he went to the grass roots with it, visiting probably every county medical society and district society in the state of Michigan many times, personally carrying the messages, the ideas, the conclusions of the administrative officers, the legislative authorities, the considered conclusions of the pioneer thinkers and policy makers which make a medical society work. He considered the most effective method of carrying on his work was by direct contact in preference to writing letters. He served the Michigan State Medical Society for twenty-three years in this capacity, traveling hundreds of thousands of miles and wearing out a car practically every year.

The last three years he also served as full-time president of Michigan Medical Service, having given up his practice in Bay City and moved to Detroit to assume these new duties in addition to continuing as State Society Secretary. He had been one of the active organizers of the Blue Shield program, he knew its problems and was ever willing to devote his time in an attempt to solve them, to smooth the way and to make the prepaid medical care program work through personal contacts with the administrators, the membership and the doctors who were rendering the service.

We pay tribute to L. Fernald Foster and his memory.

EDITORIAL EDITORIA
EDITORIAL EDITORIA
EDITORIAL EDITORIA
EDITOR
EDITOR
EDITOR
EDITOR
EDITORIAL EDITO
EDITORIAL EDITO
EDITORIAL EDITO
EDITOR
EDITOR
EDITOR
EDITOR
EDITOR
EDITORIAL EDITORIAL
EDITORIAL EDITORIAL
EDITORIAL EDITORIAL

Adequate Patient Hospital Care

We have coined a new term to cover a service which has been mentioned in this JOURNAL many times during the last several years; to cover a condition about which *Hospitals*, the Journal of the American Hospital Association, published a symposium called "Progressive Patient Care."

The Health Information Foundation of New York City sent copies of that symposium to us and probably to many others. For many years the HIF has been publishing comments, surveys and reports about the increasing utilization of hospitals, especially at a time when Blue Cross and Blue Shield had reached their acceptable stature ten years ago. Not only has there been an increase in the number of patients entering the hospitals, but a slight increase in the number of days they stayed.

It is now generally recognized that one person out of every eight will be hospitalized during each year. However, the constant urge has been to build larger and better hospitals. Surveys told us there were not enough beds to care for those patients who should be using them—a complete new picture had developed. The hospital, instead of being a place where a patient went to die, then became a place where patients went to get well. The vast majority of hospitals, while they had different types of rooms and wards for the selective use of those who could pay, have universally offered full nursing care while the patients were in the hospital.

In recent years, attention was called to the fact that there were not enough nurses, nurses' aides and nurses assistants to give individual attention to each patient. Desperately ill patients were compelled to have private nurses. That was the rule and still is—when nurses can be secured. The extremely ill patient needs from one to three private nurses to serve during the day and night—to be always on hand ready to take care of an emergency—to give the patient the treatment and attention advised or ordered. Even then there was a delay many times when the nurse had to chase down the hall for a syringe, a hypodermic needle, an ampule of something for shock, medication for pain, a bed pan or urinal.

Hospital beds were filled to capacity, many times having patients in the halls. Under these circumstances, the internist, the generalist, or the surgeon who had a sudden call—a patient with a heart attack, one in diabetic coma, one with a ruptured gangrenous appendix—the doctor could not get a bed because they were all full; that is, unless he could discharge one of his own patients who was on the road to recovery. About four or five years ago, it was estimated that approximately one third of patients in our major hospitals could be ambulatory and could be moved into self-care units; and some could even be sent home under proper supervision.

In the July, 1956, issue of THE JOURNAL, page 830, the suggestion was made that in connection with establishing a new area unit in Detroit, which involved the four major hospitals and 240 acres of slum land, instead of building new top class hospitals as was contemplated, some really modern nursing homes, senior citizen homes, and convalescent homes, be built to accommodate this surplus of patients. Instead of costing the patient or Blue Cross around $35.00 or more a day, the patient could be cared for at a cost from $6.00 to $10.00.

"The Patient Gets A Break"

The Saturday Evening Post for January 2, 1960, had an article entitled "The Patient Gets a Break." *Medical Economics* for December 21, 1959, had an article entitled "Progressive Hospital Care—What It Means for You." Those members who are interested in the best "adequate" medical care their patients can get, should read these articles. They are eye openers and place this question of hospitalization squarely before the public. We have had many comments and queries already.

In January, 1952, at St. John's Hospital, a 170-bed hospital at St. Paul, Minnesota, the administrator, Carl Ave'Lallenant, established a complete modification of the usage of the beds and facilities. He arranged in one room with no reference to disease, just illness, a complete emergency situation with eight beds, two nurses and aides. Into this room, he put his intensely ill patients. The nurses were there all the time and the house physician or the attending physician were there many times during the day.

These patients immediately began to respond and to improve within two to three days. The constantly present staff and the immediate contact could give these seriously ill patients the best possible care.

The second unit in this hospital was "general care halls" which included the patients who in most parts of the country are being taken care of in hospital beds as general bed patients. Department number

three was a much larger one, twenty patients per nurse, but just as important for a proper balance, where patients were not confined to bed. They had their own clothing, took care of their own bath and toilet requirements, went to the cafeteria or dining room for their meals and had television, cards and recreation. Section number four, also with a couple of nurses on hand, was the rehabilitative care unit where the necessary training and teaching for handicapped or crippled is carried out.

In section number five, still under the hospital supervision and contact with visiting nurses, the patients are sent home. These are mostly patients with long continuing illnesses such as stroke, heart, and like ailments. A vocational therapist also visits them and sees that they continue their treatment.

In March, 1956, Edward J. Thorns, of Memorial Hospital in Manchester, Connecticut, had the same idea and developed a similar program. In April, 1957, the hospital opened a unit for the seriously ill, and a do-it-yourself unit for the ambulatory. A year later, the rehabilitation unit was added. Many hospitals throughout the country are now considering these programs.

Last year, in discussing the entirely and completely new insurance program which the Michigan State Medical Society had developed for "the old age and retired citizen with meager income and inadequate finances," Blue Shield found that a program could be built for a few cents over $3.00 per month. At that time, it was suggested that hospital care would not be solely a hospital service.

Michigan would not be able to reach that low figure because of the utilization of hospitals as was then being done. Several of the Blue Cross programs in other states recognized nursing homes and convalescent homes and authorized payment up to $10.00 for them.

On December 28, 1959, the Michigan Insurance Commissioner approved a program by which Michigan Hospital Service can do an experimental job limited to about 1,000 cases, where the nursing or convalescent home feature will be employed, and home care will be given by the use of visiting nurses or technicians. This program is experimental and is limited to one year.

Hospital Utilization

In its report up to September 30, 1959, Michigan Hospital Service gives the following figures. For the first quarter of 1954, there were 1,005 hospital days per thousand subscribers. That item was given for each quarter, and in the second quarter of 1959 (the last one reported), there were 1,237 hospital days per thousand subscribers. In just five and a half years, there was an increase of over 23 per cent.

At the same time, the average days per entry, that every subscriber stayed in the hospital in 1954 was 7.28, then 7.36, 7.39, 7.60, 7.64 and 7.70. These two items, without considering any increase in costs of hospital days, such as labor, would account for a very serious increase in hospital cost.

The hospital cost of the "intensive care" or the adequate care program, which we have outlined has been figured out in a number of instances, and there are quite a number of hospitals doing it. The first charges were $52.00 to $55.00 a day for the intensive charge and scaling down to $20.00 a day for the rehabilitation and fourth stage in the hospital. The final results were that patients went home one day earlier in the majority of cases than under the previous method of hospital care. This intensive service is costly—but it saves lives.

There is an intensive service unit in operation in Battle Creek Community Hospital which has been going for a little over four months. The installation was assisted or financed by the Kellogg Foundation. The reports from the doctors who are using it are most glowing in every way. The patients are getting extraordinarily good care and are responding much quicker than under the old method of hospital service plus private nursing or special nursing. A small daily extra charge is made for the two or three days that the patients are in this unit, but it saves practically every one of them several whole days of special nursing which now costs about $57 a day.

The unit has not been functioning long enough to make any final report, but just the one private nursing item is a big saving. One or two days of private nursing saved cuts down the total costs by that much. The hospital is also considering the establishment of a third unit which will be partially self-care and immediate recuperation before being discharged from the hospital.

Blodgett Memorial Hospital in Grand Rapids has had an intensive care unit for two years, in which time they have taken care of over 450 patients. The experience with this arrangement has been very satisfactory and its advantages far outweigh any possible disadvantages.

Within the past year they have also developed an intensive care unit for the pediatric section. These units are probably the first in Western Michigan.

A query at University Hospital in Ann Arbor shows

that plans are practically completed for an intensive service unit, the location being the most important factor now. It is believed that an ambulatory or self-help unit is not necessary because a similar service is now available in the nature of a hotel where the patients are kept while ambulatory. These editorials were written January 9. On January 15, an announcement was released from Detroit that the hospital authorities and the city governing board had approved final steps in clearing out 240 acres and over 600 families from the area near the four big hospitals in Detroit to construct the most impressive medical center in the world.

What an opportunity to do some far-reaching research in hospital construction and utilization; supplying accommodations for senior citizens, areas for ambulatory or self-help patients; and many other experiments in the most modern thought on hospital utilization and construction.

We are entering a new decade, and progress is fast.

Michigan Chiropody Association Takes Issue

In the October, 1959, number of THE JOURNAL of the Michigan State Medical Society, we published a paper prepared by Michael E. Ellis, M.D., of Grand Rapids, entitled "The Case for Medicine to the People." A prominent doctor in Grand Rapids, who had read the paper, sent it to the editor for publication. In reviewing the paper, the editor failed to see anything unfavorable to other professions.

On January 5, a communication was received from the Executive Secretary of the Michigan Chiropody Association, calling attention to the fact that the article classed chiropodists as "cultists." He also called attention to action of the AMA Judicial Council some twenty years ago that: "the practice of chiropody is not a cult practice . . . the Council can see no reason to declare the teaching of chiropodists by members of this organization (AMA) to be unethical."

He continues to say:

"Recognition of chiropody is by no means unanimous. The profession is, however, generally recognized by a number of state and federal agencies and groups. These include the Veterans Administration which pays chiropodists in private practice for services rendered; and which employs chiropodists in VA hospitals throughout the country; the Armed Services which commission chiropodists and have done so since the time of Abraham Lincoln who commissioned Isachaar Zacharie as Chiropodist General of the United States Army; Medicare which pays for services by chiropodists; the Michigan State Department of Mental Health which employs chiropodists in six of the mental health Institutions."

We communicated with Dr. Ellis, and he is willing to withdraw the term "cult" as referring to chiropody. The AMA House of Delegates at its last two sessions recommended that we cease to use the word "cult" in referring to any group in the quasi-medical field. We were much interested in the historic information presented, and hope this misunderstanding can thus be explained.

Council Election

Harold J. Meier, M.D., Coldwater



The Council, at its annual meeting, January 29-30, 1960, elected Harold J. Meier, M.D., Councillor of the Third District, as Chairman of The Council to replace A. E. Schiller, M.D., of Detroit, who resigned as Chairman on account of health conditions, but remains as Councillor of the First District in Detroit.

Harold J. Meier was born in Grand Rapids in 1904. In 1906, the family moved to Grand Ledge, where he attended public schools and graduated from high school in 1922. He entered the University of Michigan at that time as a premedical student and in 1925 entered the medical school, from which he graduated in 1929. He was a member of Alpha Omega Alpha and Phi Beta Phi fraternities.

After graduation, Dr. Meier spent two years in hospital training at Columbia and Children's Hospitals in Milwaukee, paying special attention to orthopedics. He was in group practice in Burlington, Wisconsin, for five years and in 1936 located in Coldwater, where he did general practice and general surgery. The years from 1942 to 1945 were spent in the armed forces, and he was discharged with the rank of major. Following his army service, he continued further training in his specialty, taking short courses and basic science courses with some residence work in clinical orthopedics. For the past seven years, his practice has been confined to surgery of trauma.

Dr. Meier has been active in organized medicine since 1947, serving on various state committees and has been an alternate delegate and then delegate from Branch County since 1938. He was elected Councillor for the Third District in 1955. He has two daughters and three grandchildren. Dr. Meier has been interested in numerous civic and other affairs in Coldwater.

"Fern was a Doctor's Doctor, Parent's Doctor, Patient's Doctor."

By Howard T. Knobloch, M.D.

Whenever I reminisce about Doctor Foster, a veritable fusillade of vivid memories passes in review before my eyes.

My initial contact with Fern originated by a letter of inquiry concerning the possibility of forming a joint association in the practice of Pediatrics in Bay City. At this time, in October, 1939, I was serving a residency in Pediatrics at the Northern Michigan Children's Clinic in Marquette, Michigan, under the masterful clinician, M. Cooperstock, M.D. Dr. Foster had decided that because of the enormity of his practice and the heavy demands of time exacted by the State Society, and his infant brain child, Blue Shield, it would be wise to create a partnership. He was particularly interested in me as a possibility after learning from "Dr. Coop" that I was a native Pennsylvanian and had served as a house officer at the Children's Hospital in Philadelphia, where he had acquired his post-graduate training in Pediatrics.

Our first and only interview resulted after mutual agreement by correspondence and occurred on a Sunday in November, 1939, at his home on McKinley and Johnson. I had quartered at a tourist home Saturday night and on my arrival at Foster's was privileged first to meet his lovely wife, Katie, who made me feel welcome as the flowers in May. She informed me that there was a raging epidemic of scarlet fever and Fern was swamped with house calls. About two hours later, the good Doctor entered the scene brimming with unbridled zest and appearing fresh as a daisy, after making six visits with five to go.

* * *

MY FIRST IMPRESSION OF this dynamo of energy, stamina and boundless drive was one of utter amazement and sheer admiration. Here was a man with the poise and aplomb of a Mickey Mantle in batting practice facing the firing squad with a shrug and a chuckle.

His quip was, "This is just a routine Sunday, and the poor kids can't help it."

He chided me for not reporting in to his bailiwick Saturday night and asked me to go along on calls with him. After three hours of concentrated conversation, work and a conducted tour jam-packed with action, we returned to his home. I was fired with enthusiasm and had already decided that Bay City was my locale of destiny.

By mutual agreement and verbal contract we pledged a partnership on the spot with a few wrinkles to be ironed out. I was fully convinced à la the great Foster magnetism that, far and wide, Fern was unapproachable as a man of integrity and a physician of high ideals and merit.

One of the first bits of advice my boss bequeathed me was not to call him Louis (his first name) after expressing a fond antipathy for this epithet. The entire first evening was spent in acquiring a de-



MARCH NUMBER DEDICATED TO L. FERNALD FOSTER, M.D.

tailed indoctrination into the practice of medicine in these environs as rendered brilliantly by Doctor Foster.

My exhausted state of reverie was severely jolted into abject reality when at the end of the harrowing day L.F.F. casually mentioned that he planned to attend a convention of the AMA in Atlantic City two days hence for only a matter of two weeks. This meant that I would rudely be thrust into the breach of full pediatric practice all alone, on my very own, without his most able assistance and guidance. My first timorous impulse was to run for the Pennsylvania hills, but being quite bereft of pecunia and a practical person, I was easily dissuaded and L. Fernald assured me that, "There really is nothing to it, especially for a man of your background and training."

* * *

DOCTOR FOSTER IS INDUBITABLY recognized as the "Father" of Pediatrics in the Bay City area, having been the first and only pediatrician for the period of 1920 to 1927 when Dr. McClain entered here in the specialty of medical care of infants and children. Doctor Foster was the first member of the American Academy of Pediatrics in Bay City and encouraged me to take my examinations as soon as possible. This enabled me to become the second member of this specialty in May, 1941. His pleasure in knowing I had passed my examinations was heightened immeasurably by a humorous incident which happened at the Children's Hospital in Chicago, when I accidentally set off the fire alarm at six A.M. Sunday in the nurses home. His comment, "Just a country boy in the big city."

Fern Foster, always a pioneer at heart and a rugged individualist of the highest caliber, inaugurated his medical career in Bay City with unswerving determination and tenacity of purpose. Immediately, he made his magnetic personality and forceful influence felt. At first, he was not openly received and his endeavors were fraught with obstacles and obstructions in the form of direct opposition and head-on collision by the older competing practitioners. However, with his always radiant personality and persistent diplomacy he exerted a constant powerful, positive momentum and within a few years all barriers were lifted as a fog before the sun, and he received rapidly the full acclaim and recognition of all of his colleagues. His practice grew by leaps and bounds to a very thriving and flourishing one within five years.

One of his early trademarks was the new red Cadillac which he cherished. Like himself, his car was at all times a model of cleanliness, neatness and unblemished spotlessness. His car received continual expert attention and was washed and polished at least once a week.

Fern was always a fashion plate in sartorial dress and a true Beau Brummel DeLuxe. His clothes were impeccable in taste, quality, modernity, neatness and color combination. He seldom ever wore one suit more than one day. He was always well shaven, with not a hair out of place and shoes well shined, regardless of weather, time of day or type and degree of work engaged in.

* * *

FERN WAS A DOCTOR'S Doctor, a Parent's Doctor and a Patient's Doctor all rolled into one. His bedside manner and art of medicine were irreproachable. He was especially adept and skillful in placating disturbed parents and inspired the utmost confidence regardless of the severity and critical nature of a child's illness. All the parents revered his advice and counsel as Biblical truths and would follow him to the ends of the earth. His explanations of illness were practical, logical, simple and easily understandable and were geared to the degree of intelligence of the parent. It was truly uncanny to see him analyze a complicated situation and almost invariably come up

---

About This Number

Following the death of L. Fernald Foster, M.D., on May 27, 1959, The Council of MSMS recommended that a future number of the JOURNAL of the Michigan State Medical Society should be dedicated to Doctor Foster.

In planning the material for this March number, it was decided not to eulogize Doctor Foster, as was done in the JOURNALS at the time of his death, but rather to relate some lesser-known, personal facets of his service to medicine. Such an article—warm and friendly—was written by Howard T. Knobloch, M.D., long-time associate of Doctor Foster at Bay City.

with the correct answer. He was at all times a champion fireman and could completely satisfy the most irate parent with the gravest complaint. He would merely gaze unperturbed out of the window with a warm smile and a hearty "Ho-ho-ho" and in a matter of minutes or seconds the parents would reverse entirely from an attitude of deep anger to one of complete happiness and compliance. His proclivity in persuasiveness and reassurance left an indelible and lasting impression on the parents and their progeny.

* * *

IN FACT WHEN HE asked me to make house calls on his old patients, I could sense their keen disappointment and lack of satisfaction in my efforts as representing a very poor substitute at my best.

Fern had the patience of a saint and was tireless in his endeavor, satisfying with unhurried answers the long lists of questions and interrogations regardless of their importance. He sincerely felt that any call by a parent was justified and important if that person honestly felt so. He greatly enjoyed making home calls and welcomed this special opportunity to understand the emotional, psychic and physical climate and background for the patient's illness. He wielded an exceedingly sharp sense of perception and used to the utmost his special senses and intuitive skill as an expert diagnostician. To him, humility was a true virtue and when confronted with a person inclined to arrogance he would remark, "You can always tell a man from Harvard, but you can't tell him much."

He was imbued with the philosophy that in medicine a physician renders a service unbiased by the desire to sell a product but dedicated to rendering a decision to the patient's best interests and state of health. His fees were constantly reasonable and commensurate with a patient's ability to pay, and he felt strongly that monetary benefits in medical practice were secondary to the personal satisfaction derived from helping the suffering and the salvaging of life. If a doctor rendered his best efforts, the financial rewards would take care of themselves.

* * *

A MOST COMMENDABLE attribute of Fern was his powerful and unrivaled ability to hold his practice despite the tremendous demands of time in absentia. Even yet, his brother practitioners never cease to comment with utter amazement on this almost unbelievable feat of accomplishment. Fern's intense drive and versatility in handling with ease many major duties is little short of the miraculous. His stamina was most inhuman when one recalls that he would drive to all parts of the state delivering speeches and attending meetings in adverse weather for several days and nights and on his return would with a few hours of sleep engage in a full day of arduous medical practice, punctuated with a myriad of telephone calls pertaining to not only medical practice but affairs of state, county and city. It seems as though everyone relied heavily upon his sagacity to solve personal, medical, social and civic problems—and he invariably would. At all times he was affable, gracious, polite, courteous, convivial and cheerful to those who sought his help. It was his firm conviction that the busiest and hardest working person always could find time to perform additional tasks and duties.

* * *

IT WAS AN ELECTRIFYING experience to hear Fern pick up the telephone and respond with a most melodious and mellifluous soothing "Hellooo," peculiar only to him. This characteristic phonation occurred regularly at all hours. I know of no one else who could awake from a deep sleep and instantly supply sharp, crisp answers to involved perplexing questions as though his mind was thoroughly exercised by several working hours. He seemed always to be at his calm, cool and collected best when under fire and when the going was roughest.

As a lasting tribute to his position as the King of Secretaries, his fellow physicians showed their esteem by keeping him on the job as County Medical Society Secretary for thirty-three long years. He considered the County Society as the keystone and fountainhead of organized medical practice.

Fern was a true epicurean and enjoyed savory nutriments as well as anyone. He would travel far and wide for a good steak and often would order seafood from a special culinary establishment in Delaware.

As a chain smoker par excellence, Fern showed most unusual control in being able to smoke a cigarette one half to three quarters of the way without spilling the ashes except at the precise time of their disengagement into an ash tray.

* * *

ONE OF THE OUTSTANDING memories of my practice with Doctor Fern revolves about tonsil and adenoid extirpation by kitchen table surgery before the days of Blue Cross insurance. This ordeal was an eminently successful, well-planned operation and highly scientific in all aspects. The children were well selected and were examined carefully the day preceding operation and had a urinalysis, hemoglobin, bleeding and clotting time done where indicated. They were well conditioned psychically, and the parents prepared the surgical settings.

Dr. Urmston in most cases was the surgeon and he schleutered the tonsils, resulting in negligible blood loss. Dr. Urmston carried sterilized instruments and the suction machine while Dr. Foster furnished the anesthetic equipment. Fern Foster was a master anesthetist with children and the best, to my knowledge. He carried them deep enough to please the operator but with plenty of safety margin and they always awoke within a few minutes following the operation. He always left the parent with a printed list of instructions to follow post-surgically, and in many cases requested a nurse to help the mother. His particular delight was the office T and A operation, and for this purpose he had a most elaborate setup.

To my knowledge, of all the hundreds of T and A's done by this method, the mortality rate was zero, and the morbidity rate was practically zero. In fact, my older two children had their tonsils and adenoids removed on the kitchen table. Fern contended that the positive arguments for this modus operandi were the safety factor, the patient awakened in his own bed, with his mother at his side and slept in his own bed the night before and the night after, and was spared the startling and shocking sight of masks, gowns, strangers and complex operating room equipment. I am sure his patients had many fewer nightmares following their throat surgery. He would wax eloquent and a gleam would appear in his eyes while he described the operation in detail to a parent.

His similes were always commonplace and crystal clear when he illustrated by words like "unhinging and unscrewing the tonsils, and it's like shelling peas from a pod or peeling a chicken gizzard."

Fern was a champion of the art of placation of a parent. Especially adept was he in relieving the anxieties of a distraught mother with an infant possessed of colic. After a few moments of conversation, a mother would show almost complete relaxation and a most happy expression of relief. Undoubtedly, the colic would evaporate into thin air directly. He was especially skillful in talking to parents who had a child with congenital heart disease, and his comfort in this situation was most effective. His management of upper respiratory disease and pneumonia and otitis media were also masterpieces. with results not too much less effective than those in comparison following the era of specific antibiotics. His success with problems concerning vomiting, diarrhea and fever were well nigh phenomenal. Special prescriptions for cough, colic, diarrhea, worms and fever originated by Fern were avidly copied and utilized by his colleagues.

His keen sense of humor was a striking attribute, and regardless of the unctuousness of any situation, he could always uncover a humorous incident to lessen the gravity and suspense.

* * *

FERN WAS ESPECIALLY PROUD of the student nurses he taught at Mercy Hospital, for in all of his many years of instruction not one ever failed to pass her State Board examinations. He gave unstintedly of his time, not only in this field, but also he was extremely active in civic affairs of various interests.

He was exceedingly enthralled by the many facets of the Fire Department and was awarded a special badge of merit. He attended all the fires when possible and helped greatly in the choice of fire engines and equipment.

He served ably on the School Board locally and was quite active in promoting the PTA organization at Washington School.

He was intensely interested in sports locally, statewise and nationally, attending many high school football games, Detroit Lions, Red Wings and Tiger sports events. He would recall with a happy sparkle his rabid enthusiasm about the Bay City baseball team in the days of Ki Ki Cuyler when he attended almost every game.

He fostered state and local interest in Crippled Children and Rheumatic Fever programs.

Doctor Foster was deeply imbued with a feverish conviction of the individual's inalienable human rights to his basic freedoms when applied in a constructive manner. One freedom especially important to him was the patient's right to choose the physician of his selection. He was diametrically and unalterably opposed to socialized medicine in any form. This torch he carried throughout life, and it became stronger and stronger with the passage of time. The Government did not buy groceries, clothes, furniture or homes for the people, so why should it buy medicines and medical care, except for selfish aggrandizement of power politics. Besides, the staggering and stupendous cost of such a malicious undertaking would destroy personal initiative and make income taxes oppressive and unbearable. In addition, the inferior service rendered would turn back medical progress to the medieval ages.

* * *

HIS ONE GREAT WEAPON to block this confiscation of human rights was perhaps the highest highlight of his illustrious contributions to organized medicine, viz: Blue Shield and Blue Cross.

I feel deeply indebted to Doctor Foster in many ways for the help he has very unselfishly given to me.

He aided me materially in beginning pediatric practice by his display of courage, wisdom and foresight and by his moral support. His greatest gift was that of imparting to me a working knowledge of the true art of medicine. I had learned the scientific know-how, but its practical application was another matter. In my association with Fern, I was enabled to establish the all-important contacts with my fellow doctors, hospital administration and personnel and the parents of prospective patients.

His positive personality and character traits have greatly conditioned and influenced my attitudes, reactions and responses in my practice and daily life. He has been an inspiration to me in my public speaking engagements and in handling many tasks and problems confronting me.

L. Fernald Foster was a thoroughbred champion, man, doctor, statesman, diplomat, friend, advisor and humanitarian.

"Friendly, Helpful, Kindly"

I first met Dr. Foster many years ago, when I was the guest of the Bay County Medical Society and he was its secretary. I noted even then the smoothness and efficiency with which he conducted the proceedings of the Society.

During the many years that followed and particularly after he became the secretary of the State Society, our contacts were many but in our official capacities and as close personal friends, one could not help but admire the smoothness and efficiency with which he conducted the meetings, both large and small, in which the affairs of our State Society and the welfare and health of the public were concerned. He was punctilious and efficient, but always friendly, helpful and kindly in his approach.

It was my privilege to be of service to him in a professional capacity, and I can testify that he was a very cooperative patient, but he had to carry on Society matters even in the hospital.

I was so happy when he accepted the presidency of Michigan Medical Service, and was able to serve nobly during a very trying and critical period.

The medical profession of Michigan and of the nation are all the better off because Fern Foster lived and gave so much of himself.

He has gone on, but his good works live on as his enduring monument!

LOUIS J. HIRSCHMAN, M.D.

"Fern Helped Journals"

An ancient fable reminds us that "honest men esteem and value nothing so much in this world as a real friend." Fernald Foster proved himself such many times over, not alone to me, but to the many State Medical Journal editors in those trying days of the early '40's.

Fern Foster's contributions to organized medicine reached far beyond the boundaries of his adopted State of Michigan. His capacity to organize and direct was early recognized in the reorganization of the Cooperative Medical Advertising Bureau and the formation of its successor, the State Medical Journal Advertising Bureau. Much of the improvement which has been accomplished in the final product of our State Medical Journals is due to Fern Foster's leadership in developing the biennial Journal Conference of the Bureau.

The cordial handshake, the smile, the jovial remark which characterized this fellow Kappa Sigma endeared him to me and made him indeed a real friend. I sorely missed his presence at our national medical gatherings during the final months of his valiant struggle for his survival.

The unselfish utilization of energy for his fellow physicians and his perseverence to maintain the highest ideals of our profession were a never failing inspiration to me.

STANLEY B. WELD, M.D., *Former Editor, Connecticut Medical Society Journal*

Michigan State Medical Society

Annual Session of the Council

January 29-30, 1960

HIGHLIGHTS

- Annual Reports of the Secretary, Treasurer, and the Editor were presented, thoroughly discussed by Reference Committees and approved (see pages 463-470).
- The Auditor's Report for the year 1959, and budgets for 1960 were approved (see page 470).
- Reports of the three Standing Committees of The Council (County Societies, Finance, and Publication), meetings of January 28, 1960, routinely were referred to Reference Committees, and approved by them and The Council with minor amendments.
- H. J. Meier, M.D., Coldwater, was elected Chairman of The Council to succeed A. E. Schiller, M.D., Detroit, who resigned as Chairman but remains Councilor representing the First District.
- Secretary D. Bruce Wiley, M.D., Utica; Treasurer Wm. A. Hyland, M.D., Grand Rapids; Editor Wilfrid Haughey, M.D., Battle Creek, were re-elected for the year 1960.
- Progress Report on Michigan Hospital Service (Blue Cross) was presented by MHS President John N. Lord of Detroit.
  Progress Report on Michigan Medical Service (Blue Shield) was presented by MMS President G. Thomas McKean, M.D., Detroit.
- The Presidential Program (five-year plan) was the subject of a progress report by President Milton A. Darling, M.D., Detroit, and President-Elect K. H. Johnson, M. D., Lansing
- Veterans Administration Home Town Medical Program: a new contract effective April 1, 1960, was approved, subject to the same reservations expressed by the Michigan State Medical Society when the 1959 contract was renewed.
- 1959 MSMS House of Delegates Resolution Number 26 urging that geriatrics chairs be established in the two medical schools in Michigan: letters from Dean W. N. Hubbard, Jr., M.D., of University of Michigan, and Gordon H. Scott, Ph.D., Wayne State University, indicated that the resolution met with his favor but that operating funds were needed to accomplish the purpose of the resolution.
- Relative Value Study: A letter from the Wayne County Medical Society requested that The Council take no action on approving or disapproving the RVS should that study be reported before the House of Delegates Annual Session, September, 1960. Discussion pointed out that the study would not be ready prior to the 1960 House of Delegates session, and the Wayne County Medical Society request was approved.
- Appointments: (1) Richard M. McKean, M.D., Detroit, was appointed MSMS representative to the University of Michigan research project on electrolyte balance; (2) MSMS Committee to Meet With Michigan Funeral Directors Association to discuss ambulance driver education and regulation: P. T. Mulligan, M.D., Mt. Clemens, Chairman, Harry A. Towsley, M.D., Ann Arbor, H. W.

Harris, M.D., Lansing; (3) Nominations to National Foundation for its state committee on health scholarship program: A. Jackson Day, M.D., Frederick J. Fischer, M.D., and Robert A. Sobel, M.D., all of Detroit; (4) MSMS delegate-alternate to Michigan Health Council: R. W. Teed, M.D., Ann Arbor, as delegate and K. W. Toothaker, M.D., as alternate; (5) K. H. Johnson, M.D., Lansing, to Advisory Council of Michigan Practical Nurses Association; (6) A committee composed of the President, President-Elect, Chairman of The Council, and Secretary was appointed to meet with Executive Director Wm. J. Burns to discuss office procedure and delineate staff duties.

- Speaker J. J. Lightbody, M.D., Detroit, reported that the Committee to Cooperate with National Blue Shield held a meeting on Sunday, January 17 with the National Blue Shield representatives and that considerable ground had been laid for future study by the joint committee. Next meeting would be held on Sunday, February 14. R. L. Novy, M.D., Detroit, and Donald H. Stubbs, M.D., Washington, D. C., were elected co-chairmen of joint study committee. The Speaker also reported that the House of Delegates Committee on Financial Structure (O. K. Engelke, M.D., Ann Arbor, Chairman), had begun its function and will hold its first meeting on February 16.

- The Council instructed that the quarterly reports to delegates, issued in 1959, shall be continued in 1960.

- Meeting dates changed: The date of the 1964 Annual Session was moved up to the week of September 20 in order not to conflict with a city-wide Shriners convention; the date of the 1961 Michigan Clinical Institute was changed to the week of March 5, in order not to conflict with the Chicago Medical Society Conference.

- Honor for Wilfrid Haughey, M.D., Battle Creek: Fifty years ago, Dr. Haughey was a member of the AMA House of Delegates. Suggestion was made that this matter be invited to the attention of the Michigan delegates to AMA House of Delegates so a fitting recognition might be arranged in June, 1960, at AMA convention.

- MSMS Group Life Insurance Program: progress report indicated that as of January 26, a total of 1,383 members was insured, with $12,857,000 insurance in force. Ten death claims had been paid, totaling $69,500, with one pending.

- The following committee reports were presented: (1) Child Welfare Committee, meeting of November 5; (2) Relative Value Study Committee, November 5; (3) Prevention of Highway Accidents, November 12; (4) Tuberculosis Control Committee, November 18; (5) Geriatrics Committee, December 2; (6) Committee on Scientific Work, December 9; (7) National Defense Committee, December 9; (8) Postgraduate Medical Education Committee, December 10; (9) Liaison Committee with Health Insurance Council, December 16; (10) Rheumatic Fever Control Committee, December 16; (11) Maternal Health Committee, January 7; (12) Legal Affairs Committee, January 7; (13) Geriatrics Committee, January 16; (14) Medical Care Insurance Committee, January 20; (15) Committee to Meet With Michigan Funeral Directors Association, January 20; (16) Liaison with Michigan State Board of Registration in Medicine, January 13.

- Report of Legal Counsel included Opinions on (1) whether total health and accident premium can be regarded as a medical deduction for income tax pur-

poses—opinion was that only the health insurance portion of the premium is deductible; (2) can parents under the age of twenty-one grant permission to do surgery on their child—opinion was that parents can grant permission regardless of their age; (3) legality of a nurse administering anesthetic on a fee-for-service basis, if not under the supervision of a doctor of medicine—opinion was that a registered nurse can lawfully administer anesthetic but only under the personal and direct supervision of an M.D.; if this is not the case, the operating physician becomes responsible; (4) opinion that county society mediation committees should be available to insurance companies the same as to any individual (which opinion was approved by the Reference Committee and by The Council).

- Public Relations Counsel's Report included progress of medical bills before the Michigan Legislature; House of Delegates resolution re medical student recruitment program; request for authority to purchase two motion pictures; progress report on film of new MSMS headquarters building; and plans for meeting with Congressional leaders May 3-4.

- Michigan Health Commissioner A. E. Heustis presented three matters (1) report on paralytic polio in Michigan; (2) improved local needy county health departments; (3) improved program for the care of the aged. The Council went on record as supporting the three projects provided compulsory vaccination as a precedent to enter school is not an invasion of one's Constitutional rights.

- Progress report on new MSMS headquarters: W. R. Jarratt and Richard Wood of the office of Minoru Yamasaki & Associates gave a review on construction progress on the new MSMS headquarters building; mechanical and engineering work is proceeding in the basement of the building; the precast aggregate surface concrete roof vaults and support columns are being formed in Detroit under close supervision of the architect; as soon as completed and seasoned, they will be transported to the building site and quickly installed. The matter of landscaping and irrigation system was referred to the Big Look Committee for study and report.

- Upon recommendation of the Finance Committee, The Council earmarked $1.00 per member's dues for the year 1960 only, to the Beaumont Memorial Foundation, for the improvement and furnishing of the Beaumont Memorial on Mackinac Island.

- The Council referred to Blue Cross and Blue Shield the request that they adopt the policy of coverage for spouses of deceased members of MSMS in the physicians' group contract (#40,000).

- The Council approved the recommendation "that the Publication Committee of The Council assume responsibility as the Editorial Board for "The Journal"; that all editorials shall be submitted to the members of that Committee; that it is the intent of this action that the Publication Committee, acting as the Editorial Board, assume with the Editor the responsibility for all editorials printed in "The Journal" and shall act in a consultative capacity for other items in "The Journal."

- The Council approved the recommendation of the Publication Committee that a new publication on economic currents be inaugurated and be sent to approximately 1,000 members of medical and related organizations, to contain in graphic form latest economic information on medicine.

SECRETARY'S ANNUAL REPORT—1959

TO: The Council of the Michigan State Medical Society:

I herewith submit the annual report of the Secretary for the year 1959.

MEMBERSHIP

The Michigan State Medical Society membership for 1959 showed a total of 6,652 members including 45 military members, 352 Associate members, 297 Life members, 84 Retired members and 2 non-resident members. The total paid membership was 5,872 with net dues of $351,606.00. The 1959 membership once again established a new record for the Society. The number of members with unpaid dues for 1959 was 19, the lowest in history.

DEATHS DURING 1959

I must regretfully report a total of one hundred and twelve deaths among members during the past year.

Bay County—Joseph C. Grosjean, M.D., Bay City; Walter S. Stinson, M.D., Bay City; Lars W. Switzer, M.D., Saginaw; James W. Wilcox, M.D., Bay City.

Calhoun County—Manley J. Capron, M.D., Battle Creek; John E. Cooper, M.D., Battle Creek.

Delta County—Arthur J. Carlton, M.D., Escanaba.

Dickinson-Iron County—Geron Frederickson, M.D., Iron Mountain.

Genesee County—Arthur C. Blakeley, M.D., Detroit; Max R. Burnell, M.D., Flint; John T. Connell, M.D., Flint; Southard T. Flynn, M.D., Flint; Kendall Hooper, M.D., Flint; Edwin P. Vary, M.D., Flint; Orill N. Reichard, M.D., Flint.

Grand Traverse-Leelanau-Benzie—Fordyce H. Stone, M.D., Beulah.

Hillsdale County—Carl L. Davis, M.D., Hillsdale; Elihu A. Martindale, M.D., Chelsea; Harry C. Miller, M.D., San Diego, California.

Houghton-Baraga-Keweenaw—George F. Brewington, M.D., Las Vegas, Nevada.

Ingham County—Raynold J. Cook, M.D., Lansing; Leonard L. Henry, M.D., East Lansing; George R. Landy, M.D., Lansing; Hugh R. Meyer, M.D., Lansing; Frank Stiles, Jr., M.D., East Lansing.

Ionia-Montcalm—Alfred E. Hollard, M.D., Belding; Charles H. Peabody, M.D., Youngstown, Ohio.

Jackson County—Wayne A. Cochrane, M.D., Jackson; Frank J. Gibson, M.D., St. Petersburg, Florida.

Kalamazoo County—James W. Barnebee, M.D., Kalamazoo; Ralph G. Cook, M.D., Kalamazoo; Ralph B. Fast, M.D., Kalamazoo; Ralph W. Shook, M.D., Kalamazoo; Walter J. Siemsen, M.D., Kalamazoo.

Kent County—George H. Baert, M.D., Grand Rapids; William L. Bettison, M.D., Grand Rapids; Earle J. Byers, M.D., Grand Rapids; Harry R. Eggleston, M.D., Grand Rapids; Nicholas E. Lanning, M.D., Grand Rapids; Lemoyne I. Unkefer, M.D., Comstock Park; Carl W. Uthoff, M.D., Grand Rapids.

Lapeer County—David H. Burley, M.D., Almont.

Lenawee County—W. B. Hornsby, M.D., Clinton; Horace H. Loveland, M.D., Escanaba; Philip P. Sayre, M.D., Onsted.

Livingston County—Bernard H. Glenn, M.D., Fowlerville.

Luce County—Earl H. Campbell, M.D., Newberry

Marquette-Alger—Benzion C. Baron, M.D., Munising; Foster A. Fennig, M.D., Marquette; Paul C. LeGolvan, M.D., Washington, D. C.

Mason County—Roger S. Morris, M.D., Ludington.

Mecosta-Osceola-Lake—Louis L. Peck, M.D., Barryton.

Midland County—Charles N. Giering, M.D., Midland.

Monroe County—Thomas A. McDonald, M.D., Monroe; Olin E. Parmelee, M.D., Lambertville.

Muskegon County—Axel W. Anderson, M.D., Twin Lake; Norman A. Fleishman, M.D., Muskegon; Lunette I. Powers, M.D., Traverse City.

North Central Counties—Martin A. Martzowka, M.D., Roscommon; Gordon L. McKillop, M.D., Gaylord.

Oakland County—Edward V. Howlett, M.D., Pontiac; James A. Morton, M.D., Pontiac.

Oceana County—Louis P. Munger, M.D., Hart; Fred A. Reetz, M.D., Shelby.

Saginaw County—Robert F. T. Jaenichen, M.D., Saginaw; E. G. Schaiberger, M.D., Birch Run.

Shiawassee County—Carleton A. Harkness, M.D., Owosso.

Washtenaw County—Frank H. Bethell, M.D., Ann Arbor; Edward A. Cary, M.D., Ann Arbor; Harold A. Miller, M.D., Saline; Herman H. Riecker, M.D., Ann Arbor.

Wayne County—Raymond B. Baer, M.D., Detroit; Sydney K. Beigler, M.D., Detroit; Albert E. Bernstein, M.D., Detroit; Alexander W. Blain, M.D., Detroit; William H. Bradshaw, M.D., Detroit; William J. Cassidy, M.D., Detroit; Robt. H. Clifford, M.D., Detroit; Milton D. Comfort, M.D., Flat Rock; Alexander Cruikshank, M.D., Detroit; Paul W. Dubois, M.D., Detroit; Carl A. Fettig, M.D., Grosse Pointe Park; L. Fernald Foster, M.D., Detroit; Fordus V. Hand, M.D., Detroit; LeRoy C. Harris, Jr., M.D., Baltimore, Maryland; Wesley Harrison, M.D., Detroit; Arthur L. Higbee, M.D., Detroit; A. E. Hillenbrand, M.D., Detroit; Harold A. Horkins, M.D., Detroit; Werner Kersten, M.D., Detroit; Harry Kirschbaum, M.D., Detroit; Charles W. Knaggs, M.D., Detroit; Hartman A. Lichtwardt, M.D., Detroit; Nur M. Malik, M.D., Detroit; Emil V. Mayer, M.D., Detroit; M. Ruth McGuire, M.D., Detroit; John D. McKinnon, M.D., Highland Park; William O. Merrill, M.D., Detroit; Julius Michels, M.D., Detroit; Edward J. O'Brien, M.D., Detroit; Grover C. Penberthy, M.D., Detroit; James D. Rogers, M.D., Wyandotte; Eugene H. Roney, M.D., Detroit; Thomas Sage, M.D., Detroit; Frederic Schreiber, M.D., Detroit; Clarence V. Smith, M.D., Detroit; D. F. Strohschein, M.D., Detroit; Cleary N. Swanson, M.D., Detroit; Albert G. Walters, M.D., Detroit; Frank A. Weiser, M.D., Detroit; John G. Williamson, M.D., Dearborn.

Wexford-Missaukee—Philip H. Paye, M.D., Cadillac.

ORGANIZATIONAL ACTIVITIES

1959 ANNUAL SESSION

The past year the Annual Session was held in Grand Rapids with a total attendance of 3,085. This includes 1,516 doctors of medicine including thirty-five from out-of-state. The General Assembly type of program was continued.

MICHIGAN CLINICAL INSTITUTE

The thirteenth Michigan Clinical Institute was held in Detroit, March 10 through 13, 1959. The total registration was 2,975 including 1,511 doctors of medicine. Again the Operating Room Nurses Conference was held in conjunction with the MCI as well as the Seminar for Residents, Interns and Senior Medical Students. Michigan's Foremost Family Physician, seven other members of MSMS serving as presidents of national medical associations and eleven honorees received special awards for distinguished services to medicine and the people of Michigan at a testimonial luncheon held during the MCI.

ANNUAL SECRETARY'S-PUBLIC RELATIONS SEMINAR

The 1959 County Secretary's-Public Relations Seminar was held on January 31-February 1, in Detroit and was attended by 226, an increase over the previous year.

SECRETARY'S LETTERS

As a part of the Society's general educational and informational program for individual members and for component County Societies, during the year 1959 five Secretary's Letters were issued, three to all members and two to County Society Officers. These informational bulletins were in addition to the monthly issues of THE JOURNAL with its scientific articles and informative news items. In addition, eleven Legislative Bulletins were issued to keymen during the 1959 legislative sessions to keep the membership informed of activities in the State Legislature pertaining to the practice of medicine. Also, a special letter to all members regarding the Business Activities Tax was issued during the year.

COMMITTEES

Again, time and space preclude the listing in detail of the many activities of all the committees contributing to the splendid programs of the State Society. The accomplishments of the committees of the Society were achieved at the expense of many hours of personal sacrifice on the part of their M.D. personnel. During 1959 a total of 102 meetings were held by our eighty-two committees. Practically every meeting was covered by your Secretary or Executive Director or one of the staff members. A total of 602 Society members gave freely of their time to attend these meetings and assist in the operational activities of the State Society. Too much commendation cannot be accorded the committee members who contributed so generously to develop and execute constructive programs—both scientific and economic for the public welfare and to maintain the position of leadership enjoyed by the Michigan State Medical Society in the field of progressive medical planning.

NEW SERVICES FOR MEMBERS

To add to the fine Health & Accident Insurance plan available to members of the Michigan State Medical Society, during 1959 a group life insurance plan was formulated and placed in operation. Response has been gratifying from the membership and claims already have been paid. Your Society is constantly reviewing the activities of other state and national associations and studying services provided by them. Many of these programs may be adapted to the needs and desires of the MSMS members, at some future date when fully studied and a systematic appraisal has been made by a special committee of the Society.

Also, during 1959 work was begun on the new MSMS Headquarters Building in East Lansing and the cornerstone was laid during a ceremony on September 27. It is anticipated that occupancy of the new headquarters will be completed during the summer of 1960. This new headquarters will provide more modern facilities in a prestige location and aid in the development and execution of additional services to all members.

FINANCES

An audit of the Society's books covering twelve months was completed by Auditors Knostman & Smith as of November 30, 1959. This has been submitted to the Finance Committee for study and is available to any member of the Society for perusal at the Executive Office, 606 Townsend Street, Lansing, Michigan. A brief summary of the audit produces the following information:

Assets:	
Cash	$ 38,366.18
Accounts Receivable	30,367.37
Investments	166,629.49
Property and Equipment	273,550.72
Other Assets	2,062.28
Total Assets	$510,976.04
Liabilities:	
Accounts Payable	$ 14,374.90
Society Equities:	
(Reserved for Special Purposes)	
Public Education Reserve	$ 23,527.22
Public Education Program	19,651.34
Public Service Account	8,683.54 CR
Professional Relations Account	9,134.49 CR
Rheumatic Fever Control Program	3,275.12
Building Maintenance Fund	4,936.60
New Headquarters Fund	125,188.04
New Headquarters—Under Const.	159,334.14
General Society Equity	178,506.71
	496,601.14
Total Liabilities and Equities	$510,976.04

It should be noted that the financing of the New MSMS Headquarters Building now under construction involves the securing of additional funds from a commercial bank at a favorable rate of interest and the temporary use of the MSMS Public Education Reserve which also stands as an obligation of the MSMS to be eventually re-established.

THE JOURNAL

The following financial information relative to THE JOURNAL is found in the annual audit report of Knostman & Smith. Income was $152,615.26 which is $25,040.26 over the estimated budget for 1959 (this included $8,747.63 from allocations of members' dues). Expenses were $143,794.88 which was $16,219.88 over the estimate for 1959. These figures however, result in a net gain for the year of $8,820.38 on JOURNAL activities.

1959 HOUSE OF DELEGATES

The Ninety-fourth Annual Session of the Michigan State Medical Society's House of Delegates was held in Grand Rapids, September 27-30, 1959.

The House of Delegates:

1. Adopted with thanks the Speaker's remarks; the President's remarks, the President-Elect's remarks; the report of Delegates to the American Medical Association; the report of Woman's Auxiliary to Michigan State Medical Society; the report of the Michigan State Medical Assistants Society; and the amended report of the Reference Committee on the Michigan Medical Service report.

2. Approved the amended report of the Reference Committee on Annual Reports of The Council including recommendations (a) to send MSMS representatives to Washington, D. C., in 1960 on Michigan Day; (b) to arrange Councilor Conference prior to the 1960 Annual Session; (c) to have an evaluating team visit those county medical societies that request same. The Annual and Supplemental Reports of Committees of The Council were approved, with commendation.

3. Adopted Annual Reports of House of Delegates Committees: (a) Permanent Advisory Committee on Fees; (b) Committee on Committees; (c) MCIC Study on Alternate Methods of Payment to Non-participating Physicians. Took no action on (a) Report of Study Committee on Term of Councilor; and on (b) Annual Report of Ad Hoc Study Committee on Regional Election of MMS Board Members, pending action of Liaison Committee with Blue Shield Medical Care Plans.

4. Adopted Annual Reports of all Standing Committees and of all Special Committees of The Society except one recommendation of the Mental Health Committee re membership on Michigan Medical Service Board of Trustees.

5. Approved presentation made by the Chairman of the Blue Shield Medical Care Plans (except Item 5, page 7 re National Account Agreement; the House of Delegates recommended to Michigan Medical Service that it adopt this Agreement) and referred the entire problem of relationship of Michigan Medical Service and the Michigan State Medical Society to a Special Liaison Committee with the Blue Shield Medical Care Plans (a committee of the House of Delegates).

6. Adopted Resolutions concerning: (a) Memory of the late L. Fernald Foster, M.D.; (b) Kalamazoo State Hospital's Centennial; (c) Freedom of Choice of Contract in Michigan Medical Service (as amended); (d) Hospital Committee Reports, prevents subpoena (referred to Legal Affairs Committee); (e) MMS Board of Directors: publish nominations for; (f) MSMS Sponsorship of Michigan Medical Service; (g) MMS Board of Directors: Maximum Term of Members; (h) Adoptions; (i) Geriatrics Chairs in Medical Schools (as amended); (j) House of Delegates' Committee to Study Mal-practice (as amended); (k) Itemization of Blue Cross-Blue Shield Premium Notices (as amended); (l) Civil Defense Training Programs (as amended); (m) Medical Student Recruitment (as amended); (n) Other Professions: Reduced Fees to Senior Citizens (as amended); (o) Commendation to Medical Care Insurance Committee; (p) Delegates' Handbook Listing of MSMS Officers.

7. Adopted Substitute Resolutions concerning: (a) Modification of M-75 to $5,000 Income Limit; (b) Reaffirming 1957 Statement of Principles (as amended); this resolution was referred to the Liaison Committee with Blue Shield Medical Care Plans; (c) MMS: Participating and Non-participating Physician to be paid in same manner (as amended); (d) Creation of House of Delegates' Standing Committee on Constitution and Bylaws; (e) Michigan Medical Service: Family Income Determination; (f) Transmitting Council minutes to Delegates; (g) Transmitting Council minutes to County Society Secretaries; (h) Michigan Medical Service: Study of Remuneration for Prolonged and/or Complicated Cases (referred to Liaison Committee with Blue Shield Medical Care Plans); (i) MMS: Determining Total Annual Family Income.

8. Referred to MSMS Maternal Health Committee a Resolution re Pre-natal Health Program of Michigan Department of Health.

9. Took no action on the following Resolutions: (a) MMS: Promote Sale of Deductible and Limited Service Contracts; (b) House of Delegates to Approve Prepayment Plans Contracts (referred to Liaison Committee with Blue Shield Medical Care Plans); (c) American Association of Physicians and Surgeons Membership; (d) Spring Session of MSMS House of Delegates (ruled out of order).

10. Disapproved the following Resolutions: (a) Portion of Dues Rebated to County Society for Local Public Relations Program; (b) MMS: Changes in Public Advertising.

11. Amended the MSMS Bylaws: (a) Chapter 16, Section 2: Dues Delinquency Date Change; (b) Chapter 6: Transposing Sections 11 and 12; (c) Chapter 16, new Section 4: Reduced Dues for Younger Members so Privileged by their County Medical Societies; (d) Chapter 11, Section 3: Eliminate Cancer Control Committee; (e) Chapter 11, Section 1-(e): Change name of Legislative Committee to Legal Affairs Committee; (f) Chapter 4, Section 4: Include Death as Reason for Refund of MSMS Dues; (g) Chapter 11, Section 5: Membership on Ethics Committee; (h) Chapter 12, Section 3: Election of Four Delegates to A.M.A. in Alternate Years (as amended); (i) Chapter 12, Section 3: Terminology of "meeting" and "session"; (j) Chapter 6, Section 6: Investigative Procedures; (k) Chapter 7, Section 3: Investigative Procedures.

Adopted Substitute Resolution Concerning Bylaws' amendments to Chapter 10, Section 7 re Editor to be Elected by House of Delegates, but referred this matter to a special House of Delegates Committee to Study MSMS Publications.

Deferred for one year proposed amendments to Constitution: (a) Article X, Section 1 re Election of Secretary by House of Delegates; (b) Article X, Section 1 re Election of Treasurer by House of Delegates; (c) Article X, new Section 3 re Voting Privileges of Secretary and Treasurer. Tabled for one year proposed amendment to Bylaws, Chapter 11, Section 2 re membership on Postgraduate Medical Education Committee.

Amended and referred to a special House of Delegates Study Committee a proposed amendment to Bylaws, Chapter 9, Sections 1-2 and Chapter 10, Section 2 re Councilors to be members of House of Delegates. Other investigations were referred to this Special Committee.

Disapproved Resolutions re amendments to Bylaws: (a) Chapter 6, Section 6: Investigation of Misconduct; (b) Chapter 16, new Section 4: Deferment of Dues; (c) Deletion of Chapter 7 re Grievance Committee; (d) Chapter 6, Section 7, to delete "dismissal" in last sentence; (e) Chapter 5, Section 3-(e) re Active Membership for Armed Forces, Public Health Service, and Veterans Administration Officers.

12. Elected the following officers:

(a) Wm. A. Scott, M.D., Kalamazoo, as Councilor of the 4th District (1961)—to fill the unexpired term of Ralph W. Shook, M.D., deceased.

(b) B. M. Harris, M.D., Ypsilanti, as Councilor of the 14th District (1964).

(c) R. J. Mason, M.D., Birmingham, as Councilor of the 15th District (1960)—to fill the unexpired term of D. Bruce Wiley, M.D.

(d) Wm. Bromme, M.D., Detroit, as Councilor of the 18th District (1964).

(e) W. A. Hyland, M.D., Grand Rapids (1961), J. S. DeTar, M.D., Milan (1961), C. I. Owen, M.D., Detroit (1961), and O. J. Johnson, M.D., Bay City (1961), as Delegates to the American Medical Association.

(f) J. R. Heidenreich, M.D., Daggett (1960—to fill the unexpired term of Ralph W. Shook, M.D., deceased), W. W. Babcock, M.D., Detroit (1961), G. B. Saltonstall, M.D., Charlevoix (1961), J. M. Wellman, M.D., Lansing (1961), and B. M. Harris, M.D., Ypsilanti (1961), as Alternate Delegates to the American Medical Association.

(g) K. H. Johnson, M.D., Lansing, as President-Elect.

(h) J. J. Lightbody, M.D., Detroit, as Speaker of the House of Delegates.

(i) H. F. Falls, M.D., Ann Arbor, as Vice-Speaker of the House of Delegates.

13. Elected Archer A. Claytor, M.D., Saginaw, as Michigan's Foremost Family Physician for 1959.

14. *Presented Fifty-Year Awards to:*
Corwin S. Clarke, M.D., Jackson; Henry Cook, M.D., Flint; Ferdinand Cox, M.D., Jackson; Walter L. Finton, M.D., Jackson; E. V. Joinville, M.D., Detroit; John S. Lambie, M.D., Birmingham; Ralph W. Ridge, M.D., Wyandotte; John T. Sample, M.D., Saginaw; and Emma L. W. Sheppard, M.D., Fenton.

15. Elected to Special Memberships:

(a) *Thirty-nine members to Life Membership*—Branch County: Walter J. Bien, M.D.; Calhoun County: William R. Chynoweth, M.D., and James R. Jeffrey, M.D.; Genesee County: John J. Kurtz, M.D., Robert D. Scott, M.D. and Nell M. Ward, M.D.; Houghton-Baraga-Keweenaw County; John J. Burke, M.D., Raymond E. Hillmer, M.D. and Alfred LaBine, M.D.; Ingham County: Oscar H. Brugel, M.D. and Alfred J. Drolett, M.D.; Jackson County: Randall M. Cooley, M.D., Starr L. Kline, M.D. and Miar J. McLaughlin, M.D.; Kalamazoo County: William C. Huyser, M.D., William G. Hoebeke, M.D. and R. A. Morter, M.D.; Kent County: Walter W. Oliver, M.D.; Lapeer County: Daniel J. O'Brien, M.D.; Muskegon County: Charles B. Fleishmann, M.D.; Northern Michigan Counties: Frederick C. Mayne, M.D.; Oakland County: Frank B. Gerls, M.D. and Campbell Harvey, M.D.; Wayne County: Charles W. Balser, M.D., Clarence A. Berge, M.D., Perry S. Black, M.D., Julius Y. Burnstine, M.D., Laurence A. Chrouch, M.D., Harold E. Clark, M.D., John F. Demaray, M.D., Harry H. Goldberg, M.D., Howard Havers, M.D., Ellis R. Green, M.D., Charles Lemmon, M.D., Harold L. Morris, M.D., Clarence V. Smith, M.D., Benjamin R. Springborn, M.D., Peter L. Warner, M.D., and Henry R. Carstens, M.D.

(b) *Fourteen members to Retired Membership.*—Calhoun County: Kenneth B. Keeler, M.D.; Houghton-Baraga-Keweenaw Counties: Charles R. Smith, M.D.; Ingham County: Octavius M. Randall, M.D. and Abraham A. Steiner, M.D.; Kent County: Laurence W. Hayes, M.D., Leland M. McKinley, M.D. and Carl A. Sustrong, M.D.; Livingston County: Jesse J. Hendren, M.D.; Muskegon County: Carl A. Wilke, M.D.; Oakland County: Lionel N. Merrill, M.D.; Wayne County: William E. Jahsman, M.D., Harley L. Krieger, M.D., Bruce C. Lockwood, M.D. and Gordon B. Myers, M.D.

(c) *Seventy-one members to Associate Membership.*—Kalamazoo County: Howard C. Lavender, M.D.; Oakland County: Kenneth E. Corrigan, Ph.D., H. S. Hayden, Ph.D.; Washtenaw County: Francis J. Allaire, M.D., James B. Beatty, M.D., John R. Beljan, M.D., Ralph L. Brandt, M.D., Jack L. Court, M.D., Charles A. Cunningham, M.D., Richard S. Dillman, M.D., Richard H. Earle, M.D., Charles H. Eid, M.D., William R. Feltner, M.D., Richard C. Field, M.D., James B. Fish, M.D., Paul W. Gikas, M.D., William C. Grabb, M.D., Gordon J. Grout, M.D., N. Harry Hing, M.D., F. Deborah Johnson, M.D., Robert F. Johnston, M.D., Robert H. Joseph, M.D., W. W. Kimbrough, M.D., Frederick J. Kingery, M.D., Charles F. Krausse, M.D., Edwin H. Kroon, M.D., Richard A. Kutcipal, M.D., Theodore R. Lamott III, M.D., Edwin H. Lewis, M.D., Jose J. Llinas, M.D., Marvin J. Lubeck, M.D., W. Frank Matthews, M.D., Jack D. McCarthy, M.D., John M. McGehee, M.D., Leo J. Miedler, M.D., Earl M. Mumford, M.D., Thomas C. Murphy, M.D., Harold A. Oberman, M.D., John O'Sullivan, M.D., Roy Patterson, M.D., Frank N. Ritter, M.D., George W. Schemm, M.D., Bernard S. Silverstein, M.D., Iver F. Small, M.D., Purcell Smith, Jr., M.D., David B. Stevens, M.D., Clarence H. Tannel, M.D., John B. Wear, Jr., M.D., Jack C. Westman, M.D., Eugene I. Winkelman, M.D., and Lawrence H. Wilk, M.D.; Wayne County: John G. Bayles, M.D., Sidney Berman, M.D., H. L. Buller, M.D., H. Neill Calkins, M.D., Jacob L. Chason, M.D., Emerson O. Evison, M.D., Lionel Finkelstein, M.D., Barbara A. Hardt, M.D., Lewis G. Harmon, M.D., Lawrence J. Jamison, M.D., W. H. M. Johnson, M.D., George M. LeGalles, M.D., Philip L. Lathrop, M.D., Elizabeth Levy, M.D., Richard L. Novack, M.D., Robert L. Schaefer, M.D., Thomas O. Sage, M.D., Burton L. Schmier, M.D., Elwood A. Sharp, M.D., and John E. Webster, M.D.

PUBLIC RELATIONS

In 1959, the Michigan State Medical Society carried out its manifold functions, fully aware of the necessity of public understanding of Medicine's goals and purposes.

The House of Delegates, The Council and all MSMS Officers were acutely aware of the need for achieving better relations with our many publics.

Specifically, the MSMS PR effort was directed into eleven areas of activity:

1. Press Relations. Through personal contact of the PR staff and individual doctors, media personnel were impressed with the fact that MSMS always provided desired news information and background material. Innumerable requests for help were received and efficiently handled.

The rapport between media and local county medical societies was increased in many instances where the 1958 MSMS Media Code of Co-operation was adopted by the local society and the communication media. The code is designed to help the practitioner and the reporter tell a medical story within the framework of medical ethics and is strongly recommended for adoption by county medical societies.

2. Communications. Countless news stories were supplied to Michigan newspapers, radio and television stations. The activity of an important Society is news and through press releases, your PR staff has made it possible for an ever increasing number of the public to know and understand organized medicine on the local and state level.

Through special news releases to editors of county society bulletins, MSMS has informed its members of status of current projects and other items of interest.

3. Medical Student Recruitment. The 1959 House of Delegates instructed that the PR Committee develop a program to encourage the highest quality students to enter the medical profession. Such a plan will be reviewed by the Committee at its January meeting and will be implemented during 1960.

4. Science Fairs. The public has given enthusiastic reception to Science Fairs throughout the state. MSMS has participated, aided and encouraged county medical societies to play a leading role in these local affairs. It is encouraging to report that doctors have participated in every Michigan science fair during 1959.

5. Exhibits. The MSMS demonstration exhibit of "The Family Doctor's Office Equipment" received the top honor award as the best health exhibit at the Michigan State Fair in Detroit in September. The exhibit was shown at three other fairs co-sponsored by MSMS and local county societies: Ionia Free Fair, Saginaw County Fair and the Upper Peninsula State Fair. Co-operating in staffing the display were the MSMS PR staff, members of the county medical society, the Woman's Auxiliary and Medical Assistants Society.

6. Television-radio. Scheduled productions of the MSMS live television show, "The Family Doctor," were completed this year in Kalamazoo and Grand Rapids. The hour-long show was originally presented in Detroit during the 1958 Annual Session. Its success prompted the decision by the Public Relations Committee to produce the show over outstate TV stations to enhance public relations in all areas of the state.

In radio, the MSMS "Tell Me, Doctor" series is still being used by several Michigan stations. Also, a 15-minute health series is being continued until new programming develops. There is a growing desire on the part of radio stations for shorter programs to fit local news and music station programming.

7. Motion Pictures. As authorized by The Council, a new film is currently in production, which will document the construction and dedication of the new MSMS headquarters. The film will incorporate information on the activities in the public interest carried out by the medical profession and will be shown to public audiences in connection with the President's Five Year Program.

Based upon action of the 1959 House of Delegates urging a stepped up program for the recruitment of superior medical students, the MSMS film "To Save Your Life" is being revised and up-dated to carry out the instruction of the House of Delegates.

8. Public Relations Library. In an expanded acquisition program during 1959, the Public Relations Library has added a vast amount of valuable material which is available to MSMS members and county medical societies. Improved facilities in the new headquarters will permit more efficient operation and printed and audio-visual resources will be more readily available.

9. Brochures and Publications. After extensive revision, the MSMS medical associates recruitment brochure, "Planning Your Career," was reprinted and distributed for use by career guidance teachers and interested students. The brochure is now in its sixth printing and helps fill a vacuum in this field. Other printed pieces produced by public relations staff include posters, Annual Session and MCI programs and editorial aid and planning for the Woman's Auxiliary "Auxilium." Contributions to THE JOURNAL of MSMS are also made on a regular basis.

10. Annual Sessions—Michigan Clinical Institute. Science writers, working with press committees and staff at both sessions prepared a tremendous amount of copy on the medical news made by the clinical speakers and Michigan's Foremost Family Physician. Doctors of medicine were again most co-operative in filling speaking engagements before luncheon clubs during the two

meetings. These speaking dates are arranged by MSMS to bring lay groups in personal contact with doctors who are attending the postgraduate sessions.

The major areas of activity outlined above present a generalized picture of our Public Relations effort. As an outline of total activity, however, it is incomplete. For, in addition to these projects, the PR staff is intimately involved in service to the Legal Affairs Committee and its interest in new developments in health legislation. Also, the staff serves as secretaries to chairmen of the MSMS committees and functions in a liaison capacity with county medical societies, organizations and health agencies.

Additional support of the professional viewpoint was mobilized this year with the formation of the Michigan Association of the Professions. To date, there are over 3,000 charter members of the organization composed of doctors of medicine, dentists, architects, professional engineers and lawyers. The Michigan State Medical Society was one of the associations responsible for the organization of MAP. With The Council's approval, the MSMS PR staff provided valuable help to MAP in its formative stages.

The new group, first in the nation, held its first Congress of the Professions in Detroit, January 23. At pre-Congress hearings, the day previous, experts discussed legislation, public relations, education, publications and business services as these subjects related to the professions.

Wm. M. LeFevre, M.D., the organization's first president, predicted that group action on the part of all professions would be able to accomplish much that would be impossible if attempted alone.

LEGISLATION

There is some justification for us in the medical profession to look back on the past legislative year with a feeling of accomplishment.

For example, we were successful in having medical safeguards for the public incorporated in the state's new 1959 psychologist registration law. We also focused legislative attention on the mishandling of accident victims by poorly trained and poorly equipped ambulance personnel; and it now appears that our efforts have stimulated the formation of an educational program, sponsored jointly by the profession and the ambulance operators. Also, a self-imposed annual re-registration fee on the physicians will henceforth provide the Board of Registration in Medicine with sufficient additional funds to enable it to better serve the public and the profession.

We cannot ignore, however, the many challenges still facing medicine. As an example of the gravity of some of those challenges, I remind you of the Forand Bill, which has been before Congress the past three years and again is up for its consideration in 1960. In this bill the advocates of socialized medicine and the regimentation of our people hope to give surgical, hospital and nursing home care (initially) to all social security beneficiaries.

Adoption of this limited program would lead inexorably to complete socialization of health care, ultimately forcing all Americans to pay for all their health care through taxation. This is bad for the patient and worse for the country.

Medicine must do its utmost, now, to prevent this from happening. We cannot permit ourselves to forget that if it is the duty of the physician to serve his patients, he must do so politically, as well as medically.

ACKNOWLEDGMENT

Your Secretary is very grateful for the helpful cooperation given him by the Council while filling out the unexpired term of the late L. Fernald Foster, M.D.

The members of the Executive Office staff have been most understanding and cannot be too highly commended for their untiring efforts and loyalty to the Michigan State Medical Society.

To everyone who has aided so generously and willingly in the discharge of his duties, your Secretary is most grateful.

Respectfully submitted,
D. Bruce Wiley, M.D.
Secretary

EDITOR'S ANNUAL REPORT

The Journal of the Michigan State Medical Society has completed Volume 58 and has presented the most material ever attempted. The twelve regular numbers were issued plus a 68 page supplement with the January number and a 112 page supplement with the September issue. The January supplement contained the proceedings of Annual Meeting of the House of Delegates. Had this material been included in the regular issue of The Journal it would have made over 250 pages and would have been very bulky and unwieldy. We therefore published this in a separately bound section. This is an advantage for several reasons but primarily it makes these proceedings available in a compact and readily consulted form for the delegates, the officers, committee members and all others who are interested in the business and proceedings of the society. With the September issue, the Directory was issued as a separate section and it contained 112 pages.

This year The Journal has continued the program established many years ago of changing its cover design with each issue, using a design which would in some respect reflect the subject matter of the particular issue. The various subject matters used in 1959 were Heart, The Doctor As A Citizen, Washtenaw County Medical Society, Cancer Control, Beaumont Memorial Foundation, Michigan Medical Service, Michigan State Medical Society Annual Session, Child Health, Geriatrics, National Defense, Tuberculosis, and Michigan Clinical Institute.

Several of these numbers were especially noteworthy and received much commendation. The May number (Beaumont Memorial Foundation) contained an unusual amount of historical material. The October number (National Defense) received plaudits because of the unique presentation of the "Atom in Peace as well as War."

In the twelve issues, we published 1045 pages of advertising, and 1,178 text pages including all material with reference to the medical profession, original articles, news items, book reviews, editorials, programs, memberships on committees, etc. The question has been raised as to whether we were running too much advertising, but advertising pages still are the lesser of the two figures.

There were 182 authors of original articles, twelve of these names appearing more than once, mostly where there were multiple authors of a paper.

There were seventy-five editorials, all but one of which were on socio-economic and legislative policy or such items, other than purely scientific. There were seventy-seven book reviews, ninety memorial notices including one about our long time Secretary, L. Fernald Foster, M.D., which was an editorial. As for many years, every month carried a President's Page with timely comments bearing the President's signature and presenting his likeness.

The Bi-Annual Conference of State Journal Editors was held in Chicago on October 26-27, 1959. Mr. O. M. Forkert of Forkert and Associates was present for his third consecutive analysis review and criticism of the various medical journals. He had been given a single copy, the April issue, of each of the journals represented in the program. Mr. Forkert complimented all the journals on the remarkable improvement made since his first contact. He explained his ratings which were (1) poor, (2) good, and (3) excellent to a high degree,

but his top rating was almost always 90, rarely 100 for point 3.

He scaled the journals individually on six different categories: (1) There were seven questions regarding the cover in which Michigan scored 100 per cent and the comment, "The best cover among all state medical journals evaluated." (2) Table of Contents page with five questions. (3) Placement of articles, features and ads with ten questions. (4) Attention, value and readability, thirteen questions. We scored poor on the question, "Do blurbs give a terse summary of the article in a manner that makes the reader want to look into the article?". (5) Photographs, cartoons and artwork, nine questions. (6) Distinctive Character and Appeal, four questions. Michigan scored 3 (excellent to a high degree) on all but one of the forty-eight items, and was awarded the trophy for the best cover.

Four trophies were given altogether to four different journals, *Rocky Mountain Medical Journal,* Michigan, Minnesota and Georgia. The trophy was a facsimile of a page of the Guttenberg Bible printed from the first movable type ever used, a 700 sheet volume printed about 1436-1440. It is an excellent etching of this piece of work which was all printed from movable type except the initials which were hand done, and some hand coloring.

We are very proud of this year's work and record. We appreciate the co-operation and assistance of various persons on the Publication Committee, on the staff at Lansing, the Assistant Editor, and the advice and counsel of the State Society officers to whom have been submitted pre-publication forms of all editorials having to do with policies and socio-economic problems. We also wish to thank the President, President-Elect, immediate Past President, Chairman of The Council, Speaker of the House, Secretary, Executive Director, Public Relations Counsel, our Legal Counsel, and numerous members of committees who were consulted when we were discussing topics with which they were familiar; also the special co-ordinators who were appointed to assist in developing the special issues of THE JOURNAL; and the Bruce Publishing Company, our printers and very capable advisors.

THE JOURNAL to date has published 688 numbers, there being only four in the first volume. The December number, 1960, will be number 700, and we might consider some special treatment at that time.

I again thank all those who have been so kind to me.

Respectfully submitted,
WILFRID HAUGHEY, M.D.
Editor

TREASURER'S REPORT

December 1, 1958, to November 30, 1959

Pursuant to my appointment as Treasurer, by the Council, January, 1959, I am submitting my report of Stewardship.

Balance on hand December 1, 1958	$ 7,119.30
Deposits 12-1-58 to 11-30-59	7,884.26
Balance on hand December 1, 1959	$15,003.56

On December 26, 1959, $5,000.00 of Cash Deposits of Treasurer's Account was forwarded to Mr. Roney of the Executive Office to be applied to the current checking account.

[This has nothing to do with the report of December 1, 1958 to November 30, 1959, but as a reminder, our balance is $5,000.00 less than the balance of December 1, 1959 (as of this date).]

I am enclosing a list of the deposits during the past twelve months, also a list of securities at present in our port-folio and in Lock Box 121 in the Michigan National Bank, in Grand Rapids.

TRANSACTIONS CONCERNING CERTIFICATES OF DEPOSIT

December 1, 1958—November 30, 1959

Proceeds of $40,000 Certificate of Deposit No. 644 (MNB) forwarded to Mr. Roney's office on October 6, 1959.

2—$5,000 Michigan National Saving Deposits Receipts.

Nos. 1160 and 1161, each dated October 24, 1957, were forwarded to Mr. Roney on October 7, 1959.

1—$60,000 invested in Michigan National Bank Savings Deposit Receipt No. 2057 during the year was cashed and the proceeds plus interest were forwarded to Mr. Roney's office on November 3, 1959.

DEPOSITS, December 1, 1958 to November 30, 1959

December 10, 1958	$ 696.93
December 10, 1958	110.00
December 19, 1958	281.25
January 7, 1959	367.70
February, 1959	—o—
March 26, 1959	1,112.50
March 31, 1959	110.00
April 8, 1959	125.00
April 22, 1959	225.00
May 16, 1959	437.50
May 20, 1959	312.50
June 5, 1959	696.93
July 8, 1959	55.20
July 27, 1959	281.25
August 26, 1959	900.00
August 31, 1959	450.00
September 3, 1959	62.50
September 24, 1959	725.00
October 6, 1959	110.00
October 23, 1959	75.00
November 17, 1959	312.50
November 17, 1959	437.50
TOTAL DEPOSITS	$ 7,884.26
Balance, December 1, 1958	7,119.30
Balance, November 30, 1959	$15,003.56

Numbers of Certificates of deposit and U. S. Government bonds in possession of the treasurer, in Lock Box 121 in Michigan National Bank located in Grand Rapids.

1—$5,000 G Bond, dated March, 1948, No. V799-030	$ 5,000
4—$1,000 K Bonds, dated August, 1954, Nos. 262-323K, 262-324K, 262-325K, 262-326K	4,000
8—$1,000 2¼% Treasury Bonds 75-80, Nos. 17469K, 17470L, 17471A, 17472B, 17473C, 17474D, 17475E, 17476F	8,000
1—$5,000 Michigan National Bank Savings Deposit Receipt No. 1162, dated October 24, 1957	5,000
1—Michigan National Bank Savings Certificate, No. 1628 dated May 29, 1958, replacing a government bond of $5,000 called in May, 1958	5,062.50
1—Michigan National Bank Safekeeping Receipt No. 4378, $25,000 United States of America 2½% Treasury Bond dated February 15, 1954, due November 15, 1961, held by the First National Bank of Chicago	25,000
1—Michigan National Bank Safekeeping Receipt No. 4536, $35,000 United States of America 2½% Treasury Bond dated 2-15-54, due 11-11-61	35,000
1—Michigan National Bank Safekeeping Receipt No. A864, $25,000 United States of America 2½% Treasury Bond, due 6-15-62, held by the First National Bank of Chicago	25,000
1—Michigan National Bank Safekeeping Receipt No. A726, $10,000 United States of America 2½% Treasury Bond, due March 15, 1970, held by the First National Bank in Chicago	10,000
Michigan National Bank Safekeeping Receipt No. A718, 5 series K Savings Bonds, Nos. Y54-843K, 846K inclusive, V49-459K, issued 6-18-54, 12 yr. maturity	45,000

MSMS 1960 BUDGET ESTIMATES

GENERAL FUND

ACCOUNT TITLE	1960 Estimates
INCOME:	
5750 members @ $65.00	$373,750.00
Less: $ 1.50 to THE JOURNAL	8,625.00
$ 9.25 to Public Education	53,187.50
$ 4.50 to Public Service	25,875.00
$ 6.25 to Professional Relations	35,937.50
$15.00 to MSMS Headquarters Fund	86,250.00
$ 1.50 to Contingency Fund	8,625.00
$ 1.00 to Beaumont Memorial Foundation	5,750.00
Balance to General Fund @ $26.00	$149,500.00
Interest and Miscellaneous Income	3,000.00
TOTAL FUNDS AVAILABLE	$152,500.00
EXPENSES: (Administrative and General)	
Printing, Mailing and Postage	$ 9,000.00
Office Supplies	3,500.00
Insurance and Fidelity Bond	2,600.00
Auditing	850.00
Salaries—Administrative and Office (Including Legal Counsel)	53,106.44
General Counsel Expense (Includes $3,600 office expense)	4,000.00
Equipment and Repairs	3,000.00
Telephone & Telegraph	6,000.00
Taxes (Other than Property)	3,500.00
Miscellaneous Expenses and Contributions	2,500.00
Employes' Retirement Trust	12,000.00
International Business Machines	1,800.00
TOTAL ADMINISTRATIVE & GENERAL EXPENSE	$101,856.44
EXPENSES: (Society Activities)	
Council Expense	$ 25,000.00
AMA Delegates and Alternates	5,000.00
General Society Travel and Entertainment	5,500.00
Officers Travel	3,600.00
Secretary's Letters and Office Expense	1,500.00
Woman's Auxiliary	600.00
Dues Collection Expense	3,500.00
TOTAL SOCIETY ACTIVITY EXPENSE	$ 44,700.00
EXPENSES: (Committees)	
Cancer Coordinating Committee	$ 1,000.00
Child Welfare Committee	200.00
National Defense	700.00
Geriatrics	300.00
Industrial Health	100.00
Iodized Salt	100.00
Legal Affairs	3,000.00
Maternal Health	500.00
Mental Health	150.00
Michigan Health Council	10,000.00
Postgraduate Medical Education	4,200.00
Preventive Medicine	200.00
Permanent Conference Committee	100.00
Rural Medical Service	100.00
Scientific Radio	1,600.00
Tuberculosis Control	350.00
Venereal Disease	100.00
Highway Accident Committee	300.00
Advisory Committee to Medical Assistants	100.00
Big Look Committee	500.00
Medical Care Insurance Committee and Secretary	13,627.00
Relative Value Study Committee	19,222.23
Michigan Joint Council on Aging	100.00
Beaumont Memorial Restoration	200.00
Miscellaneous Committees	1,500.00
House of Delegates Committees:	
Committee to Work with National Blue Shield	2,000.00
Special Committee to Review Constitution and Bylaws	300.00
Committee to Study Problem of Malpractice	200.00
Committee on Committees	200.00
Committee to Study Michigan State Medical Society Publications	200.00
Permanent Advisory Committee on Fees	750.00
Committee to Review Financial Status of MSMS	100.00
Committee to Study Election of Councilors on Geographic Basis and the Status of Councilors as Voting Delegates	100.00
TOTAL COMMITTEE EXPENSE	$ 62,099.23
TOTAL GENERAL FUND EXPENSES	$208,655.67
GAIN OR LOSS FOR THE YEAR	(L) 56,155.67
BALANCE FROM PRIOR YEARS	178,735.36
NET GAIN OR LOSS FROM ANNUAL SESSION, M.C.I., and THE JOURNAL	(G) 4,310.00
BALANCE	$126,889.69
TO PUBLIC EDUCATION RESERVE	26,472.78
TO MSMS HEADQUARTERS FUND (Bonds)	110,000.00
BALANCE TO FUTURE YEARS	(L)$ 9,583.09

BUILDING MAINTENANCE FUND

INCOME:	
Allocation from Membership Dues	—0—
EXPENSES: (8 months—through July)	
Maintenance: Utilities, Decorating, Supplies	$ 1,700.00
Salaries—Janitor	1,000.00
Property Taxes	1,178.69
Insurance—Fire and Liability	474.93
Depreciation	1,785.85
Miscellaneous Expenses	—0—
TOTAL BUILDING MAINTENANCE EXPENSES	$ 6,139.47
GAIN OR LOSS FOR THE YEAR	(L) 6,139.47
BALANCE FROM PRIOR YEARS	4,936.60
TO MSMS HEADQUARTERS FUND	—0—
BALANCE TO FUTURE YEARS	(L)$ 1,202.87

THE JOURNAL

INCOME:	
Allocation from Dues	$ 8,625.00
Subscriptions—Non-members	800.00
Advertising Sales	135,225.00
Reprint and Cut Sales	4,400.00
TOTAL JOURNAL INCOME	$149,050.00
EXPENSES:	
Editor's Expense	$ 3,000.00
Printing, Mailing and Postage	85,000.00
Reprint and Cut Expense	3,200.00
Salaries	24,440.00
Discounts and Commissions	29,000.00
Miscellaneous Expenses	100.00
TOTAL JOURNAL EXPENSES	$144,740.00
GAIN OR LOSS ON THE JOURNAL	(G) 4,310.00

MSMS NEW HEADQUARTERS FUND

INCOME:	
Allocation from Membership Dues	$ 86,250.00
Balance from Prior Years	125,188.04
TOTAL: MSMS Headquarters Fund	$211,438.04
Transferred from Bond Account (General Fund)	110,000.00
TOTAL FUNDS AVAILABLE	$321,438.04
ESTIMATED COST OF BUILDING	468,309.86
BALANCE TO FUTURE YEARS	(L) 146,871.82

ANNUAL SESSION

INCOME:	
Booth Sales (102 spaces) Detroit	$26,300.00
EXPENSES:	
Scientific Meeting	4,000.00
Exhibit	3,500.00
Registration and Hotel	900.00
State Society and Officers' Night	3,800.00
Promotion: Printing, Mailing, Postage and Scientific Work Committee	3,000.00
Press Expense	2,400.00
Salaries	6,000.00
House of Delegates Expense (Includes special guests)	2,500.00
Miscellaneous Expenses	200.00
TOTAL ANNUAL SESSION EXPENSE	$ 26,300.00
GAIN OR LOSS ON ANNUAL SESSION	—0—

MICHIGAN CLINICAL INSTITUTE

INCOME:	
Booth Sales (73 spaces) Detroit	$ 13,585.00
EXPENSES:	
Scientific Meeting	3,000.00
Exhibit	3,200.00
Registration and Hotel	600.00
Promotion: Printing, Mailing and Postage	2,535.00
Press Expense	2,000.00
Salaries	1,600.00
Residents and Interns Conference	250.00
Miscellaneous Expense	400.00
TOTAL M.C.I. EXPENSES	$ 13,585.00
GAIN OR LOSS MICHIGAN CLINICAL INSTITUTE	—0—

PUBLIC EDUCATION RESERVE

INCOME:	
Allocation from Membership Dues	—0—
Balance from Prior Years	$ 23,527.22
TOTAL PUBLIC EDUCATION RESERVE	$ 23,527.22
TRANSFERRED FROM GENERAL FUND BONDS	26,472.78
BALANCE TO 1961	$ 50,000.00

PUBLIC EDUCATION ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 53,187.50
Other Income	200.00
TOTAL PUBLIC EDUCATION INCOME	$ 53,387.50
EXPENSES:	
Committee Meetings	$ 200.00
Equipment and Repairs	3,000.00
Printing, Mailing and Postage	4,000.00
Office Supplies	2,400.00
Salaries	26,622.66
Telephone and Telegraph	1,500.00
Travel and Entertainment	5,000.00
Exhibit Expenses	1,800.00
Publications, Pamphlets, Clippings	1,500.00
Radio, Television and Cinema	3,000.00
Miscellaneous Expenses	500.00
Library	500.00
Michigan Association of Professions	2,100.00
TOTAL EXPENSES	$ 52,122.66
GAIN OR LOSS FOR THE YEAR	(G) 1,264.84
BALANCE FROM PRIOR YEARS	19,651.34
BALANCE TO FUTURE YEARS	$ 20,916.18

PUBLIC SERVICE ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 24,725.00
EXPENSES:	
Salaries	$ 12,892.00
Telephone and Telegraph	1,200.00
Travel and Entertainment	5,000.00
Rural Health Conference	132.72
Miscellaneous Meetings	9.50
TOTAL PUBLIC SERVICE EXPENSE	$ 19,234.22
GAIN OR LOSS FOR THE YEAR	(G) 5,490.78
BALANCE FROM PRIOR YEARS	(L) 8,683.54
BALANCE TO FUTURE YEARS	(L) 3,192.77

PROFESSIONAL RELATIONS ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 35,937.50
EXPENSES:	
Salaries	$ 17,936.20
Telephone and Telegraph	1,000.00
Travel and Entertainment	5,000.00
Rent to Wayne County Medical Society	1,974.78
National Meeting Expense	1,600.00
County Secretary's PR Conference	7,200.00
Woman's Auxiliary	1,600.00
Printing, Mailing and Postage	500.00
TOTAL PROFESSIONAL RELATIONS EXPENSE	$ 36,810.98
GAIN OR LOSS FOR THE YEAR	(L) 873.48
BALANCE FROM PRIOR YEARS	(L) 9,134.49
BALANCE TO FUTURE YEARS	(L) 10,007.97

RHEUMATIC FEVER CONTROL PROGRAM

INCOME:	
Grant from Michigan Heart Association	$ 8,000.00
EXPENSES: (Central Office)	
Committee Meetings	300.00
Equipment and Repairs	100.00
Payroll Taxes	100.00
Printing, Mailing and Postage	500.00
Office Supplies	50.00
Fellowships	3,000.00
TOTAL CENTRAL OFFICE EXPENSE	$ 4,050.00
EXPENSES: (Control Centers)	
Alpena	$ 300.00
Ann Arbor	700.00
Bay City	300.00
Detroit	300.00
Grand Rapids	1,500.00
Kalamazoo	1,500.00
Muskegon	—0—
Petoskey	—0—
Pontiac and Royal Oak	—0—
Saginaw	100.00
Traverse City	500.00
TOTAL CONTROL CENTER EXPENSE	$ 5,200.00
TOTAL RHEUMATIC FEVER CONTROL EXPENSES	9,250.00
GAIN OR LOSS FOR THE YEAR	(L) 1,250.00
BALANCE FROM PRIOR YEARS	3,275.12
BALANCE TO FUTURE YEARS	2,025.12

REPORT OF KNOSTMAN & SMITH

Certified Public Accountants—1959

Executive Committee of the Council
Michigan State Medical Society

We have examined the Statement of Financial Condition of the MICHIGAN STATE MEDICAL SOCIETY, Lansing, Michigan, as at November 30, 1959, and the related statements of income and expense and fund transactions for the fiscal year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying Statement of Financial Condition and related statements of income and expense and fund transactions, present fairly the position of the MICHIGAN STATE MEDICAL SOCIETY as at November 30, 1959, and the results of its operations for the fiscal year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

KNOSTMAN & SMITH
Certified Public Accountants

Lansing, Michigan
December 23, 1959

Executive Committee of the Council
Michigan State Medical Society
Lansing, Michigan
Gentlemen:

We submit the following comments relative to the scope of our examination of the MICHIGAN STATE MEDICAL SOCIETY, Lansing, Michigan, as at November 30, 1959, and to the more important items appearing in your financial statements for the fiscal year then ended.

HISTORY

The Michigan State Medical Society was organized on September 17, 1910, under the laws of the State Michigan, as a non-profit corporation. The charter has been extended for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association, and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes "The Journal of the Michigan State Medical Society."

COMMENTS

The commercial bank account and savings account maintained at the Michigan National Bank, Lansing, Michigan, were reconciled to your books of account, and further confirmed by direct correspondence with the bank as at November 30, 1959.

Confirmation of the treasurer's account, as at November 30, 1959, was received from the Michigan National Bank, Grand Rapids, Michigan, and reconciled to your books of account.

Petty cash in the Lansing office, in an amount of $304.18 was counted by our representative. The Detroit office petty cash of $50.00 was not verified.

Accounts receivable were confirmed by direct correspondence. Although not all confirmations have been returned, no negative replies have been received. An aging analysis of the accounts by the month of charge is as follows:

September, October, November	$22,218.69
June, July, August	416.25
Over six months	954.14
TOTAL	$23,589.08

The employees portion of insurance premiums, in an amount of $1,847.11, are reimbursed to the Society via payroll deductions. This balance is comprised of the following:

Retirement plan premiums	$1,842.44
Michigan Medical Service premiums	4.67
TOTAL	$1,847.11

The net cost of your retirement plan for the current year is as follows:

	Total	*Society Share*	*Employe Share*
Premium—1 year	$19,056.84	$10,216.35	$ 8,840.49
Adjustments	4,628.70	1,640.91	2,987.79
NET	$23,685.54	$11,857.26	$11,828.28
Collections from employes	$ 9,985.84		$ 9,985.84
	$13,699.70		$ 1,842.44
Due from employes in December 1959 and January 1960	$ 1,842.44		$ 1,842.44
NET SOCIETY COST	$11,857.26	$11,857.26	—0—

Employee travel advances were substantiated by non-interest bearing signed statements from the five employees to whom advances have been made.

The employee loan is being repaid through monthly payroll deduction. Interest is computed each payment date on the unpaid balance in accordance with our recommendation in 1958.

An analysis of your investments, showing changes during the current year, is set forth in Schedule 10, as well as a detail of interest received and amortization taken. All securities were confirmed by direct correspondence with the Michigan National Bank, Grand Rapids, Michigan, per their letter dated December 29, 1959.

Real estate owned, deposits, and payments on the new headquarters building currently under construction are set forth in Schedule 11, together with applicable depreciation allowances.

Prepaid expenses represent supplies purchased in 1959 that are applicable to 1960 activities.

Office equipment purchased during the period under review was charged to expense in accordance with the Society policy of not reflecting equipment as an asset.

Membership dues for year under review were reconciled to the 6,865 membership cards issued.

Income from the sale of booth space for the Michigan Clinical Institute and the Annual Session was verified by our representative and a test check of JOURNAL Advertising was in agreement with your books of account.

State and federal unemployment taxes were computed by our representative as at November 30, 1959.

Net gain for all society functions for the year ended November 30, 1959, was $57,546.40 as set forth in Exhibit "C".

Respectfully submitted,
KNOSTMAN & SMITH
Certified Public Accountants

STATEMENT OF FINANCIAL CONDITION

November 30, 1959

ASSETS

CASH ON HAND AND IN BANKS		
Michigan National Bank		
Lansing, Michigan (regular account)	$ 12,232.60	
Lansing, Michigan (savings account)	10,775.84	
Grand Rapids, Michigan (Treasurer's account)	15,003.56	
Office cash (Lansing and Detroit, Michigan)	354.18	$ 38,366.18
ACCOUNTS RECEIVABLE		
Advertising, allowances and other items	$ 23,589.08	
Due from employes-Insurance premiums	1,847.11	
Employe travel advances	500.00	
Employe loan (interest rate at 4%)	4,505.63	
	$ 30,441.82	
Less allowance for doubtful accounts	74.45	$ 30,367.37
INVESTMENTS (Schedule A) (Market or redemption value $159,061.75)		$166,629.49
PROPERTY AND EQUIPMENT (Schedule 11)		
Land—606 Townsend	$ 10,000.00	
Lot adjoining office building	6,000.00	
Land M-78 and Abbott Road	65,646.00	
Deposit on adjoining lot	500.00	
New Headquarters building (under construction)	159,334.14	
Office building $34,500.00		
Building improvements 5,664.06		
Building equipment 3,836.09		
Parking lot 1,913.60	$ 45,913.75	
	$287,393.89	
Less depreciation allowance	13,843.17	$273,550.72
OTHER ASSETS		
Prepaid expenses		$ 2,062.28
TOTAL ASSETS		$510,976.04

LIABILITIES

ACCOUNTS PAYABLE		
Federal Unemployment tax	$ 218.37	
Michigan Unemployment tax	50.52	
Withholding and social security tax	109.82	
Unpaid invoices	13,996.19	
TOTAL ACCOUNTS PAYABLE		$ 14,374.90
SOCIETY EQUITIES		
RESERVED FOR SPECIAL PURPOSES		
Public Education Reserve $23.527 22		
Public Education Program 19,651.34	$ 43,178.56	
Public Service Account	(8,683.54)	
Professional Relations Account	(9,134.49)	
Rheumatic Fever Control Program	3,275.12	
Building Maintenance Fund	4,936.60	
New Headquarters Fund	125,188.04	
New Headquarters-Under Construction	159,334.14	
TOTAL RESERVED	$318,094.43	
General Society Equity 11-30-58 $175,021.34		
Net gain for period 3,485.37	$178,506.71	
TOTAL EQUITIES (Schedule C)		$496,601.14
TOTAL LIABILITIES AND EQUITIES		$510,976.04

STATEMENT OF INCOME AND EXPENSES

Fiscal Year Ended November 30, 1959

INCOME		
Membership dues	$159,158.25	
Miscellaneous	1.14	
Interest income (Schedule A)	8,682.15	
Amortization (Schedule A)	451.69	$168,293.23
OTHER INCOME OR (Loss)		
Annual Session	(48.33)	
Michigan Clinical Institute	(1,972.87)	
"The Journal"	8,820.38	$ 6,799.18
TOTAL INCOME		$175,092.41
EXPENSES		
Administrative and general	$ 93,085.88	
Society activity	40,823.90	
Committee expenses	37,697.26	
TOTAL EXPENSES (Schedule 1)		$171,607.04
NET GAIN		$ 3,485.37

SCHEDULE C

INCOME AND EXPENSE SUMMARY

Fiscal Year Ended November 30, 1959

	Balance 12-1-58	*Fund Transfers*	*Income For the Period*	*Expenses For the Period*	*Net Gain or (Loss)*	*Balance 11-30-59*
Equity—General Fund						
Annual Session	$175,021.34		$168,293.23	$171,607.04	$ (3,313.81)	
Michigan Clinical Institute			32,370.00	32,418.33	(48.33)	$178,506.71
"The Journal"			13,585.00	15,557.87	(1,972.87)	
			152,615.26	143,794.88	8,820.38	
Contingent Fund	53,614.34	$(53,614.34)	—0—	—0—	—0—	—0—
Building Maintenance Fund	22,195.41	(10,000.00)	—0—	7,258.81	(7,258.81)	4,936.60
Public Education Reserve	91,165.25	(76,385.66)	8,747.63	—0—	8,747.63	23,527.22
Public Education Program	17,677.72	—0—	54,121.44	52,147.82	1,973.62	19,651.34
Public Service	(5,409.09)	—0—	26,242.87	29,517.32	(3,274.45)	(8,683.54)
Professional Relations	(2,463.45)	—0—	36,460.09	43,131.13	(6,671.04)	(9,134.49)
Rheumatic Fever Control Program	1,879.18	—0—	6,825.00	5,429.06	1,395.94	3,275.12
Headquarters Fund	85,373.04	140,000.00	59,149.14	159,334.14*	59,149.14	125,188.04
New Headquarters-Under Contruction		159,334.14				159,334.14
TOTAL	$439,053.74	$159,334.14	$558,409.66	$660,196.40	$ 57,547.40	$496,601.14

*NOTE: This item represents capital expenditures in your new headquarters building currently under construction. The balance in the "Headquarters Fund" represents the funds available for construction. The balance in "New Headquarters-Under Construction" represents your current investment in your new building.

EXPENSES

Fiscal Year Ended November 30, 1959

ADMINISTRATIVE AND GENERAL

	Actual
Printing, mailing and postage	$ 11,782.68
Office supplies	3,722.67
Insurance and fidelity bonds	2,424.68
Auditing	890.00
Salaries—administrative and office—(including legal counsel)	36,301.40
General counsel expense	4,039.86
Equipment and repairs	2,880.90
Telephone and telegraph	6,548.64
Taxes (other than property)	3,431.72
Miscellaneous expenses and contributions	7,361.91
Employees' retirement trust	11,857.26
International Business Machines	1,844.16
TOTAL ADMINISTRATIVE AND GENERAL EXPENSES	$ 93,085.88

SOCIETY ACTIVITIES

Council expense	$ 20,366.63
AMA delegates and alternates	5,363.48
General society travel and entertainment	5,896.73
Officers travel	3,571.00
Secretary's letters and office expense	1,521.45
Woman's auxiliary	600.00
Dues collection expense	3,504.61
TOTAL SOCIETY ACTIVITIES EXPENSE	$ 40,823.90

COMMITTEE EXPENSES

Cancer Coordinating Committee	$ 1,109.07
Child Welfare Committee	191.93
National Defense	767.27
Geriatrics	274.79
Industrial health	35.51
Legislative	5,829.21
Maternal health	458.09
Mental health	133.66
Michigan Health Council	10,000.00
Postgraduate Medical Education	4,135.55
Preventive medicine	209.64
Permanent Conference Committee	83.30
Scientific radio	1,616.27
Tuberculosis control	371.83
Venereal disease	58.45
Highway Accident Committee	301.05
Big Look Committee	559.99
Medical Care Insurance Committee	9,531.34
Michigan Joint Council on Aging Committee	42.46
Beaumont Memorial Restoration	717.79
Miscellaneous committee expense	1,270.06
TOTAL COMMITTEE EXPENSES	$ 37,697.26
TOTAL EXPENSES	$171,607.04

INCOME AND EXPENSE OF THE ANNUAL SESSION

Fiscal Year Ended November 30, 1959

INCOME

	Actual
Booth sales (125 spaces)	$ 32,370.00
TOTAL INCOME	$ 32,370.00

EXPENSES

Scientific meeting	$ 5,106.21
Exhibit	5,285.60
Registration and hotel	1,901.52
State society and officers' night	3,989.66
Promotion—printing, mailing, postage and Scientific Work Committee	3,410.84
Press expense	2,493.31
Salaries	6,308.44
House of Delegates	3,557.95
Miscellaneous expenses	364.80
TOTAL EXPENSES	$ 32,418.33
GAIN OR (LOSS) ON ANNUAL SESSION	$ (48.33)

INCOME AND EXPENSE OF THE MICHIGAN CLINICAL INSTITUTE

Fiscal Year Ended November 30, 1959

INCOME

	Actual
Booth sales (74 spaces)	$ 13,585.00
TOTAL INCOME	$ 13,585.00

EXPENSES

Scientific meeting	$ 3,444.54
Exhibit	3,318.11
Registration and hotel	484.11
Promotion—printing, mailing and postage	2,873.94
Press	3,054.39
Salaries	1,594.44
Residents and interns conference	461.03
Miscellaneous expense	327.31
TOTAL EXPENSE	$ 15,557.87
GAIN OR (LOSS) ON M. C. I.	$ (1,972.87)

INCOME AND EXPENSE OF "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

Fiscal Year Ended November 30, 1959

INCOME

	Actual
Allocation from dues	$ 8,747.63
Subscriptions—non members	839.21
Advertising sales	138,234.37
Reprint and cut sales	4,794.05
TOTAL INCOME	$152,615.26

EXPENSES	
Editor's expense	$ 3,000.00
Printing, mailing and postage	85,273.52
Reprint and cut expense	3,296.27
Salaries	22,405.30
Discounts and commissions	29,752.77
Miscellaneous expense	67.02
TOTAL EXPENSES	$143,794.88
GAIN OR (LOSS) ON "THE JOURNAL"	$ 8,820.38

INCOME AND EXPENSE OF THE BUILDING MAINTENANCE FUND

Fiscal Year Ended November 30, 1959

INCOME	*Actual*
Allocation from dues	$ —0—
TOTAL INCOME	$ —0—
EXPENSES	
Maintenance—utilities, decorating, supplies, yard work, etc.	$ 2,224.90
Salaries—janitor	1,594.44
Property taxes	1,178.69
Insurance—fire and liabilities	474.93
Depreciation	1,785.85
TOTAL EXPENSES	$ 7,258.81
GAIN OR (LOSS) ON BUILDING MAINTENANCE FUND	$ (7,258.81)

INCOME AND EXPENSE OF THE PUBLIC SERVICE ACCOUNT

Fiscal Year Ended November 30, 1959

INCOME	*Actual*
Allocation from dues	$ 26,242.87
TOTAL INCOME	$ 26,242.87
EXPENSES	
Salaries	$ 23,026.77
Telephone and telegraph	681.00
Travel and entertainment	5,602.51
Rural health conference	197.54
Miscellaneous meetings	9.50
TOTAL EXPENSES	$ 29,517.32
GAIN OR (LOSS) DURING PERIOD	$ (3,274.45)

INCOME AND EXPENSE OF THE PUBLIC EDUCATION PROGRAM

Fiscal Year Ended November 30, 1959

INCOME	*Actual*
Allocation from dues	$ 53,920.39
Other income	201.05
TOTAL INCOME	$ 54,121.44
EXPENSES	
Committee meetings	$ 161.46
Equipment and repairs	1,613.85
Printing, mailing and postage	5,894.83
Office supplies	1,959.69
Salaries	23,026.77
Telephone and telegraph	1,399.23
Travel and entertainment	6,425.78
Exhibit expense	4,163.69
Publications, pamphlets, clippings	970.44
Radio, television and cinema	2,247.31
Miscellaneous expense	472.56
Library	483.95
Michigan Association of Professions	1,902.45
Testimonial luncheon	1,040.90
Conference on medical writing	384.91
TOTAL EXPENSES	$ 52,147.82
GAIN OR (LOSS) DURING PERIOD	$ 1,973.62

INCOME AND EXPENSE OF THE PROFESSIONAL RELATIONS ACCOUNT

Fiscal Year Ended November 30, 1959

INCOME	*Actual*
Allocation from dues	$ 36,460.09
TOTAL INCOME	$ 36,460.09
EXPENSES	
Rent to Wayne County Medical Society	$ 2,036.00
Salaries	23,026.77
Telephone and telegraph	946.14
Travel and entertainment	5,602.51
National meeting expense	2,150.61
County secretary's—Public Relations Conference	7,164.18
County society and field secretary meetings	15.00
Woman's auxiliary	1,600.78
Printing, mailing and postage	589.14
TOTAL EXPENSES	$ 43,131.13
GAIN OR (LOSS) DURING PERIOD	$ (6,671.04)

SCHEDULE A.

SECURITIES OWNED—NOVEMBER 30, 1959

UNITED STATES GOVERNMENT SECURITIES	Maturity Date	Face Value 11-30-59	Cost (Book Value) 12-1-58	Redemption or Market Value 11-30-59	Purchases During Period	Sales or Redemptions During Period	Amortization Debit or (Credit)	Cost (Book Value) 11-30-59	Interest Received to Last Interest Date
Savings Bonds—Series "G"	3- 1-60	$ 5,000.00	$ 5,000.00	$ 4,960.00	$	$	$	$ 5,000.00	$ 125.00
Treasury Bond—Series "B" 2¾%	4- 1-80-75	8,000.00	8,142.81	8,000.00			(8.92)	8,133.89	330.00
Savings Bonds—Series "K" 2.76%	6- 1-66	45,000.00	45,000.00	43,515.00				45,000.00	1,242.00
Savings Bonds—Series "K" 2.76%	7- 1-66	4,000.00	4,000.00	3,868.00				4,000.00	110.40
Treasury Bond—2¼%	6-15-62-59	25,000.00	25,000.00	23,375.00				25,000.00	562.50
Treasury Bond—2½%	3-15-70-65	10,000.00	9,840.62	8,243.75			26.56	9,867.18	250.00
Treasury Bond—2½%	11-15-61	25,000.00	24,665.62	23,765.63			167.18	24,832.80	625.00
Treasury Bond—2½%	11-15-61	35,000.00	34,466.25	33,271.87			266.87	34,733.12	875.00
Time Certificate—3-13-57									
Michigan National Bank—3%	30 days notice	—0—	40,000.00	—0—		40,000.00		—0—	1,142.23
Savings Deposit Receipt—10-24-57									
Michigan National Bank	Demand	5,000.00	15,000.00	5,000.00		10,000.00		5,000.00	441.66
Savings Deposit Receipt—8-27-58									
Michigan National Bank	Demand	—0—	30,000.00	—0—		30,000.00		—0—	1,000.00
Savings Deposit Receipt—5-28-58									
Michigan National Bank	Demand	5,062.50	5,062.50	5,062.50				5,062.50	151.86
Savings Certificate—		—0—			60,000.00	60,000.00		—0—	1,320.00
Michigan National Bank									
TOTAL SECURITIES		$167,062.50	$246,177.80	$159,061.75	$60,000.00	$140,000.00	$451.69	$166,629.49	$8,175.65
Interest on Savings Account									317.31
Interest on Loan									189.19
TOTAL INTEREST EARNED									$8,682.15

INCOME AND EXPENSE OF THE RHEUMATIC FEVER CONTROL PROGRAM

Fiscal Year Ended November 30, 1959

	Actual
INCOME	
Grant from Michigan Heart Association	$ 6,825.00
TOTAL INCOME	$ 6,825.00
EXPENSES (Central Office)	
Committee meetings	$ 115.15
Printing, mailing and postage	51.21
TOTAL CENTRAL OFFICE EXPENSES	$ 166.36
CONTROL CENTERS	
Alpena	$ 200.00
Ann Arbor	614.00
Bay City	590.00
Detroit	233.50
Grand Rapids	1,423.20
Kalamazoo	1,530.00
Muskegon	—0—
Petoskey	—0—
Pontiac and Royal Oak	—0—
Saginaw	—0—
Traverse City	672.00
TOTAL CONTROL CENTERS	$ 5,262.70
TOTAL EXPENSES	$ 5,429.06
GAIN OR (LOSS) DURING PERIOD	$ 1,395.94

PROPERTY AND DEPRECIATION ALLOWANCES

November 30, 1959

	Date Acquired	Cost	Depreciation Allowance Prior Years	Remaining Cost Beginning of Period	Estimated Life	Depreciation Expense 1959	Depreciation Allowance 11-30-59
Land—606 Townsend	1951	$ 10,000.00	$ —0—	$ 10,000.00		$ —0—	$ —0—
Adjoining lot	1952	6,000.00	—0—	6,000.00		—0—	—0—
Building—606 Townsend	1951	34,500.00	8,404.00	26,096.00	30	1,150.00	9,554.00
		50,500.00	8,404.00	42,096.00		1,150.00	9,554.00
BUILDING IMPROVEMENTS—606 Townsend							
New building entrance	1953	3,917.85	707.35	3,210.50	30	130.55	837.90
Remodel basement and storeroom	1956	1,746.21	140.66	1,605.55	30	58.21	198.87
		5,664.06	848.01	4,816.05		188.76	1,036.77
BUILDING EQUIPMENT—606 Townsend							
Lighting	1952	2,121.50	978.28	1,143.22	15	141.43	1,119.71
Boiler	1952	1,714.59	790.46	924.13	15	114.30	904.76
		3,836.09	1,768.74	2,067.35		255.73	2,024.47
PARKING LOT—606 Townsend	1953	1,913.60	1,036.57	877.03	10	191.36	1,227.93
OTHER REAL ESTATE AND DEPOSITS							
Land—M-78 and Abbott Road	8-19-58	65,646.00	—0—	65,646.00		—0—	—0—
Deposit on adjoining lot	7-24-58	500.00	—0—	500.00		—0—	—0—
New Headquarters Building (under construction)	1959	159,334.14	—0—	159,334.14		—0—	—0—
		225,480.14	—0—	225,480.14		—0—	—0—
TOTALS		$287,393.89	$ 12,057.32	$275,336.57		$ 1,785.85	$ 13,843.17

A New Medical School for Michigan

Warm, and getting warmer, are discussions on the need for, and possible location of, another medical school in Michigan.

Michigan State University boldly entered the controversy recently with a bid for the property in downtown Lansing presently occupied by the Boys Vocational School. This institution is moving shortly to new quarters at Whitmore Lake and the large expanse of grounds and commodius, though somewhat worn, buildings in Lansing will soon stand idle. Their location is contiguous to the Edward Sparrow Hospital which has just recently added new wings to raise its capacity to 391 beds.

Putting it mildly, this poses a public relations problem for the Michigan State Medical Society. Wide disparity of opinion exists among Michigan doctors of medicine. Generally speaking, there seems to be agreement that Michigan can use additional M.D.'s and this demand will increase rather than decrease as Michigan's population burgeons.

On the other hand, the best ways and means of obtaining more medical care, the real problem, enjoy no such unanimity of opinion. Some of the state's leaders emphasize that the real answer is to increase rapidly the number of medical associates rather than M.D.'s.

MSMS has expressed itself publicly as not wishing to comment at this time on the possible location of a new medical school. It has emphasized that it would be more economical to expand Wayne State University which is presently limited to accepting 125 freshmen (the University of Michigan Medical School takes 200 freshmen). Estimated costs for a new medical school start at 20 million bouncing up to 100 million, depending upon the estimator and his concept of a medical school. The State Society has also indicated the necessity for an adequate supply of clinical material being available to any new school, a situation hard to come by except in the larger metropolitan areas.

Medical educators wonder where the students would come from for a new school, in view of the difficulty that the present medical schools are having in filling their freshman classes with promising youngsters. The MSMS House of Delegates recognized this problem and urged that a campaign be inaugurated to interest good students in becoming M.D.'s. Such a campaign is being planned under the direction of the MSMS Public Relations Committee and it will be complemented by a campaign of the Michigan Health Council to obtain more medical associates.

Make Study of Discipline in Medical Profession

The American Medical Association has appointed a committee known as the Medical Disciplinary Committee which is now holding regional meetings in various parts of the United States. The primary objective is to evaluate the effectiveness of present procedures used by various state boards and other governmental agencies involved in the control of licensed professions.

A questionnaire was sent out to state boards, and medical associations early in 1958.

Several preliminary factors now appear significant—

(1) Discipline in the medical profession is a vague and undefined aim both at the legal and professional levels in medicine;

(2) The medical associations are generally powerless, except to expel from membership, in cases involving serious crimes or unprofessional conduct;

(3) State boards too frequently do not have the machinery for instituting and conducting hearings in disciplinary matters;

(4) There is little apparent concern over such serious matters as narcotic addiction or fraud and deceit in practice;

(5) Too often a "guilty" physician is encouraged to go to another state;

(6) Probation of various types is being used without any formal program;

(7) There is more emphasis in some areas on interpersonal relations than on legal and professional matters;

(8) There is a marked lack of understanding as to the role of the profession in hospital practice and relations;

(9) There is confusion as to the role of the profession in its association with the paramedical groups;

(10) The segments of the profession at the state and county levels need, and are now beginning to look for, leadership from the American Medical Association on the above matters;

(11) Failure on the part of individual physicians to recognize their responsibility in reporting ethical and professional violations; and

(12) The philosophy of the present administrators of discipline at the legal level is almost negative in some instances and of a very conservative and reluctant nature in others.

How serious is this matter? If a state cannot, or does not, for just cause, revoke a license or discipline a physician, it should take a critical look at its obligation. If there is no central authority above the pressure of individuals in which power for revocation is vested, a fatal weakness exists. If no machinery exists for investigation and hearings, and if recommendations cannot be made on the basis of established evidence, discipline does not really exist. If there is nothing beyond what the state or county society can do, a license to practice also becomes a potential license for abuse.

(Digested from *Federation Bulletin*, Federation of State Medical Boards of the U.S., Volume 47, No. 1)



AMA Report Describes Washington Situation on Forand Legislation

(This regular monthly summary of Washington news is prepared by the AMA for use in the Michigan Journal.)

Congress appears headed for a showdown this session on legislation for the Federal government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several State Medical Societies will send delegations to Washington to personally express their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

Without amplification, President Eisenhower told a recent news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, Secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. He said consideration was being given to: (1) stepped-up Federal assistance under the Federal-state public assistance program, and (2) the Federal government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand bill. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill are pointing campaigns toward securing the House Committee's approval of the legislation.

The AFL-CIO, a main supporter of the Forand bill, urges labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care for older persons.

The AMA and the Subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said:

> The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

Dr. Louis M. Orr, Orlando, Florida, President of the AMA, said:

> "This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security."

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand bill but broader in scope. The Kennedy bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services.

Germany Host to WMA

The German Medical Association, host for the XIVth General Assembly of The World Medical Association in Berlin, September 15-22, 1960, has extended a cordial invitation to all M.D.'s to attend this meeting. Special plans are already far advanced for this meeting. The German Medical Association has scheduled its own annual meeting in conjunction with the General Assembly and the opening and closing plenary sessions of the two organizations will be held together. All activities will be held in the new Berlin Convention Hall.

The convening of the General Assembly and numerous other international and national meetings in Europe during August and September provide doctors an opportunity to use the Medical Diplomat passport.

The first specific aldosterone-blocking agent...

ALDACTONE™

effectively extends the medical control of edema or ascites.
It introduces a new therapeutic principle in the treatment of...

CONGESTIVE HEART FAILURE • HEPATIC CIRRHOSIS
THE NEPHROTIC SYNDROME • IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

A New Order of Therapeutic Activity

ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

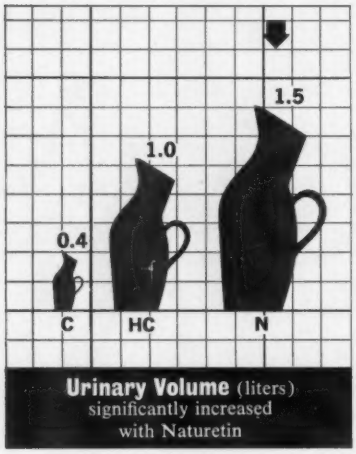
more closely approaches the ideal diuretic

Naturētin

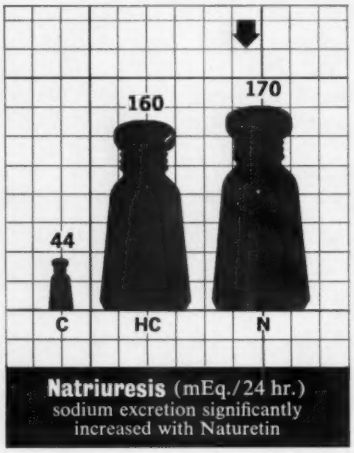
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic group of compounds, this drug [NATURETIN] shows a significantly increased natriuresis and decreased loss of potassium and bicarbonate. In this respect it more closely approaches a natural or 'ideal diuretic.' It is effective upon continuous administration and causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." *Ford, R.V.: Pharmacological observations on a more potent benzothiadiazine diuretic; accepted for publication by the American Heart Journal.*

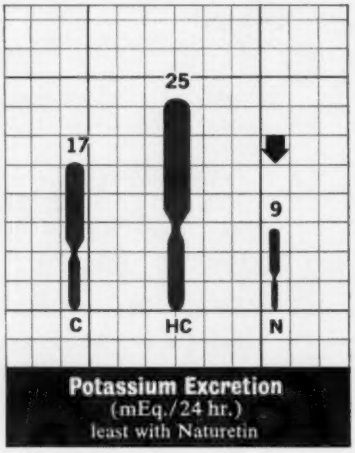
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



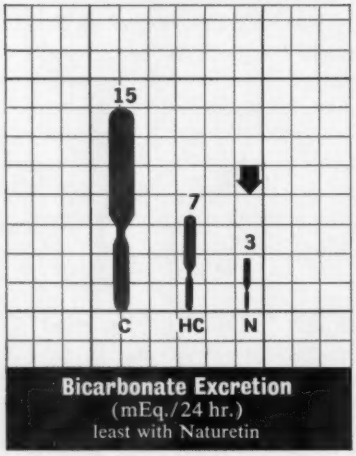
Urinary Volume (liters)
significantly increased with Naturetin



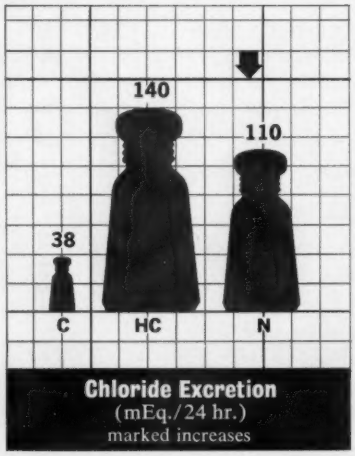
Natriuresis (mEq./24 hr.)
sodium excretion significantly increased with Naturetin



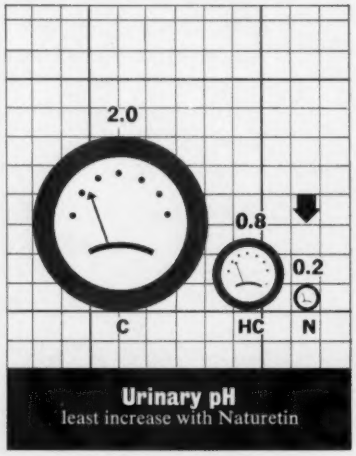
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959.

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action – in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage – more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity – few side effects – low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin – *Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin – *Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin – *Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

SQUIBB

Squibb Quality—the Priceless Ingredient

Rx Naturetin 5mg. Disp. #30 Sig: 1 each morning.

"RAUDIXIN"® AND "NATURETIN" ARE SQUIBB TRADEMARKS.

Butazolidin®

brand of phenylbutazone

in arthritis and allied disorders

proved by a decade of experience

Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

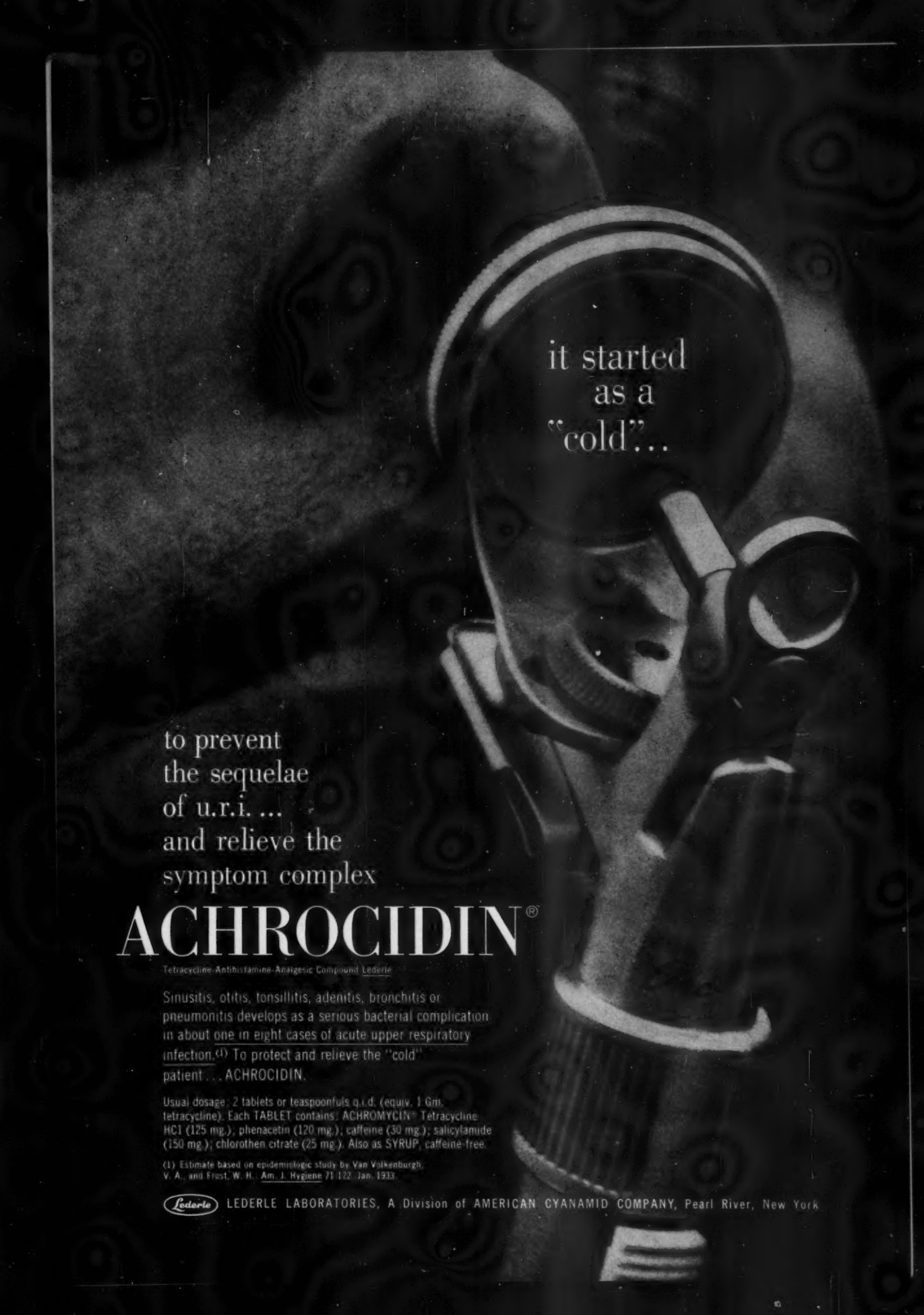
Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg.
Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York



Geigy

BU 7-60



to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient . . . ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H. Am. J. Hygiene 71:122 Jan. 1933

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

proven successful in almost every case of

skin itch



and

dryness

Used in the bath SARDO releases millions of microfine water-dispersible globules* to provide a soothing, softening suspension which enhances your other therapy. SARDO baths . . .

1 **rehydrate the dry, itchy, scaly skin**

2 **add comfort to the therapeutic care**

3 **act to measurably increase natural emollient skin oil**

4 **minimize loss of natural oil and excessive moisture with a fine non-occlusive film**

Patients will appreciate pleasant, convenient, easy to use, pine-scented SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

Sardo®
in the bath

for atopic dermatitis
eczematoid dermatitis
senile pruritus
contact dermatitis
soap dermatitis



Samples and literature yours for the asking.

Sardeau, Inc. 75 East 55th Street New York 22, N. Y.

*© 1959 *Patent Pending, T.M.*

Says Poor Reporting Could Lead to Medical Care Lag

Unrestrained reporting of medical news could be a deterrent to progressive medical care.

That possible danger was cited by Robert D. Potter, editor of *New York Medicine*, at Michigan State University recently where he presented the second annual Yates Memorial Lecture. The lecture to students, faculty, physicians and others was sponsored again by the Michigan Tuberculosis Association in memory of Charles Yates, former MTA president.

"The unrestrained reporting of medical news . . . builds up in the public mind a false picture that medical research (and physicians) can do the impossible," the speaker said.

Potter cited overzealous medical reporting as being partly the cause of an unrealistic public attitude that treatments and drugs are always "perfect" and any failures are due to doctor negligence.

True negligence, he said, should be punished. "But when a physician or surgeon is penalized for rendering the most modern and accepted treatment, then one approaches the day when new experimental treatment or operation will vanish."

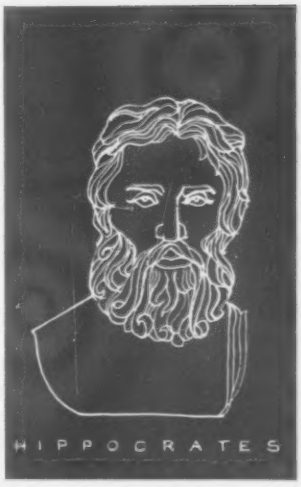
"The doctor will perhaps be thinking more about a potential lawsuit than the welfare of his patient. Or he will use bee stings instead of cortisone for arthritis," he said.

Another big job of the medical reporter, Potter pointed out, is to tell the public what is going on in the social and economic sides of medicine.

Social security medical benefits, fair hospital fees and trade union medical programs are all subjects the public needs to know about, he said.

Potter mentioned the Forand bill introduced in Congress to put compulsory health insurance into the social security program. He asked, "Is this not a form of government medicine?" "Is this what the public really wants?"

He explained that questions like these can only be answered by a well informed public. It is the job of medical reporting to give them the right information.



Pathological Society Elects

The new officers for the Michigan Pathological Society for 1960 are President John W. Rebuck, M.D., Detroit; Viola G. Brekke, M.D., Highland Park, president-elect; and James G. Wolter, M.D., Detroit, secretary-treasurer. Dr. Wolter will serve as Officer of the MSMS Section on Pathology, Radiology and Anesthesiology.

Committee on Trauma Elects

Joseph Posch, M.D., Detroit, is the new chairman of the Michigan Committee on Trauma of the American College of Surgeons. The new secretary is Wayne W. Glas, M.D., Eloise.



Presidents of the five societies (*left to right*) are N. O. Salter, P.E., Michigan Society of Professional Engineers; Milton A. Darling, M.D., Michigan State Medical Society; Murray A. Leitch, D.D.S., Michigan State Dental Association; Burney C. Veum, LL.B., State Bar of Michigan, and C. A. OBryon, Michigan Society of Architects.

William M. LeFevre, M.D., Muskegon, president of The Michigan Association of the Professions.



Hold MAP Congress

Groups representing the five professions of architecture, dentistry, law, medicine and engineering, about a year ago, established the Michigan Association of the Professions.

The infant group has been developed into an organization of more than 3,000 charter members.

A Congress of the Professions was held at the Sheraton-Cadillac Hotel, Detroit, January 23, with a preliminary day, January 22, devoted to committee hearings and a President's Invitational Banquet.

Five committees had been appointed which met at noon and outlined their work before they opened hearings. The hearings in separate rooms were (1) Committee on Education, Dr. Gordon H. Scott, Dean Wayne University School of Medicine, Chairman; (2) Committee on Business Services and Techniques, Elmer J. Manson, A.I.A., Chairman; (3) Committee on Public Relations, Charles H. MacMahon, Jr., A.I.A., Birmingham, Chairman; (4) Committee on Publications, L. M. Dunn, P.E., Port Huron, Chairman, and (5) Committee on Legislation, John G. Nolen, D.D.S., Chairman. After the open hearing, each committee outlined an official report for Congress meeting the next morning.

The President's Invitational Dinner was held in the Book Casino room with William L. LeFevre, M.D., of Muskegon, presiding as President. The toastmaster was Lester P. Dodd, J.D. of Detroit. The speaker was Dr. Kenneth McFarland, educational consultant for General Motors Corporation. Dr. McFarland, a noted lecturer, declared, "In the year ahead, Americans will be earning an annual rate of more than $400 billion and will be producing at the rate of more than $500 billions. These predictions will come true if our people make them come true. The ingredients of prosperity can do little more than exist, they must properly be mixed to produce prosperity."

He concluded, "Let us rejoice and be glad that the basic rules are working again in 1960, and that those who play by the rules may again be assured of victory. It is in this fact that we have our greatest cause for optimism as we move into a new year and a new decade."

On January 23, the Congress was called to order at 9:30 by William M. LeFevre, M.D., president. Charles H. King, Dean, Detroit College of Law, was the parliamentarian. The invocation was pronounced by Charles L. Goldstein, attorney-at-law.

The reports of committees had been mimeographed and were explained by the chairmen. After the committee reports was the election of board members.

The keynote speaker was the Honorable Gerald R. Ford, Jr., of Grand Rapids, U. S. Congressman from the Fifth District of Michigan. He said, "What I am saying has particular meaning for you and your new organization. I hold you in high regard, for I am a member of one of the professions represented here, but I ask you quite frankly whether our professional people and their organizations in the crucial struggle for the preservation of our institutions have taken the easy way out by an excessive preoccupation with political neutrality? That is a question which every individual or group in our nation should now be asking itself, individually and collectively."

The noonday meal was presided over by Floyd D. Ostrander, D.D.S., MAP vice-president. The invocation was by The Reverend Jesse Jai McNeal, Minister, Baptist Church, Detroit, and the speaker was Doctor Arthur S. Flemming, Secretary, U. S. Depart-

ment of Health, Education and Welfare. Dr. Flemming's talk was very impressive and congratulatory upon the movement being made here in Michigan by the Congress of the Professions.

The afternoon featured a President's Panel. The speakers were David D. Allman, M.D., Past President, AMA; Clark A. Dunn, P.E., Immediate Past President, National Society of Professional Engineers; Rudolph H. Friedrich, D.D.S., Secretary, Council on Dental Health, American Dental Association; Charles S. Rhyne, LL.B., Past President, American Bar Association; and John Noble Richards, F.A.I.A., President, American Institute of Architects. Every speaker commented upon the movement of an association of the professions, emphasizing the many points in which the professions are similar, and the many points in which the one may help the other.

The evening meal in the Grand Ballroom concluded the Congress. Presiding was The Honorable John R. Dethmers, Chief Justice, Supreme Court of Michigan. The invocation by The Reverend G. Merrill Lenox, Executive Director, Michigan and Detroit Council of Churches. Hugh W. Brenneman was toastmaster. The speaker was George Romney, president, America Motors Corporation, and chairman of the Citizens' Committee for Michigan. This address was broadcast over radio at 8:05 in the evening.

The aims of the Citizens' Committee for Michigan are explained by George Romney, chairman of the Committee and president of American Motors Corporation, at the closing banquet. Hugh W. Brenneman was toastmaster.





Arthur S. Flemming, left, Secretary, U. S. Department of Health, Education and Welfare, was the luncheon speaker. At right, Albert E. Heustis, M.D., State Health Commissioner.



The Honorable Gerald R. Ford, Jr., U. S. Congressman, Fifth District, gave the keynote speech.

Reveal Speakers for May 4 "Symposium on Cerebral Palsy"

A "Symposium on Cerebral Palsy" will be presented under the auspices of the United Cerebral Palsy Association of Michigan at the Wayne County Medical Society Building, Detroit, May 4.

Those who will speak and lead discussions on the following facets of the problem of cerebral palsy are:

John A. Churchill, M.D., Associate Neurologist, Henry Ford Hospital, Detroit: "Etiology, Pathology and Prevention of Cerebral Palsy."

Winthrop M. Phelps, M.D., Medical Director, Children's Rehabilitation Institute for Cerebral Palsy, Baltimore: "Early Diagnosis of Cerebral Palsy."

Brewster S. Miller, M.D., Medical Director, United Cerebral Palsy Associations, New York City: "Cerebral Palsy Today."

Meyer A. Perlstein, M.D., Children's Neurology Service, Cook County Hospital, Chicago: "Early Neurological Evidences of Cerebral Palsy."

Russell Meyers, M.D., Chairman, Division of Neurosurgery, University of Iowa: "Evaluation and Treatment."

Dr. Phelps will conduct a live clinic.

Advance registration forms will be given wide distribution; those who do not receive registration forms may register by mail with the United Cerebral Palsy Association of Michigan, 206 Hollister Building, Lansing 8.

Urges Auxiliary Members to Help Mold Public Opinion

Every one of the 80,000 members of the woman's auxiliary is in medical public relations.

How can you—a hard and willing worker in the auxiliary—help to mold public opinion on behalf of medicine and the profession?

There is no magic formula. The only way I know to achieve our aim is to keep yourself constantly informed about all the things that affect medicine and the profession.

There is no limit to an auxiliary member's influence and her ability to help other people understand the facts, especially as they relate to socio-economic affairs—hospital costs, drug costs, insurance plans and doctors' fees.

Socio, incidentally, means "the people;" economics means their pocketbooks. The term socio-economics of medicine applies to the way all different groups of people obtain and pay for their medical services.

Auxiliary members are interested in these problems. One of the best ways to keep yourself informed about them is to read *A.M.A. News* from cover to cover. Read other official medical publications. Discuss the more complex problems with your husband. Study trends not only in medicine but in allied medical fields.

—Mrs Frank Gastineau, President, Woman's Auxiliary (*Woman's Auxiliary—A.M.A. Bulletin*, Vol. 21, No. 2)

AAMA Honors Doctor Rice

John W. Rice, M.D., Jackson, is the new chairman of the advisory board of the American Association of Medical Assistants Board of Trustees. Active also with the Michigan group, Doctor Rice has been a member of the AAMA board since 1958.

The AAMA, a young fast-growing organization, seeks to offer educational programs for its members and other services so the medical assistants will be of even greater value to her physician-employer and his patients.

Charles H. Mayo, M.D.: Medicine is about as big or as little in any community, large or small, as the physicians make it.

* * *

French Proverb: People count up the faults of those who keep them waiting.

The HAVEN SANITARIUM, Inc.

Rochester, Michigan

In operation since 1932

M. O. Wolfe, M.D. — *Director of Psychotherapy*

Ralph S. Green, M.D. — *Clinical Director*

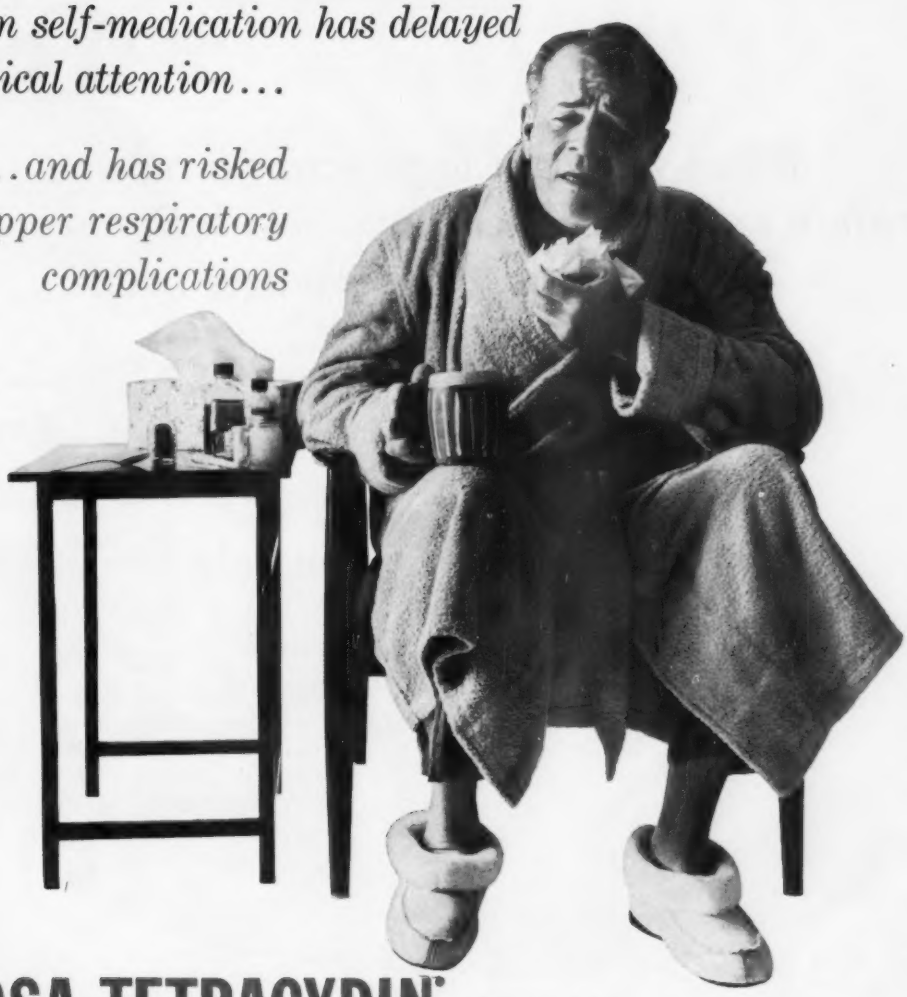
Graham Shinnick — *Manager*

A private psychiatric hospital for the intensive treatment of mental and emotional illnesses.

Telephone: OLive 1-9441

in the **"COMMON COLD"**
when self-medication has delayed medical attention...

...and has risked upper respiratory complications



COSA-TETRACYDIN® CAPSULES

Cosa-Tetracyn® – analgesic – antihistamine compound

act quickly to
- *control secondary infection*
- *alleviate cold symptoms*

each capsule contains:

Cosa-Tetracyn	125 mg.
phenacetin	120 mg.
caffeine	30 mg.
salicylamide	150 mg.
buclizine HCl	15 mg.

average adult dose: 2 capsules q. i. d.

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.*

Q.

When you want to prescribe a regimen to reduce serum cholesterol and beta lipoproteins, are drastic diet changes necessary?

a.

Fortunately, no. Often only two steps are necessary: (1) control of the amount of calories and of dietary fat, and

(2) a simple modification of food preparation method in which poly-unsaturated vegetable oil is used in place of saturated fats.

Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

Once total fat and calorie intake is adjusted, the simple replacement of *saturated* fats, used at the table and in cooking, with *poly*-unsaturated Wesson makes possible a most subtle dietary change, yet conforms completely to therapeutic requirements.

Where a vegetable (salad) oil is medically recommended as part of a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.

Say you saw it in the Journal of the Michigan State Medical Society



This flaky pie crust, *crisp cookies, Chiffon cakes, biscuits can all be made easily with Wesson. Decrease the calories of pie by preparing with single crust and a fresh fruit or gelatin filling. It is delicious.*

FREE *Wesson recipes are available in quantity for your patients, showing them how to prepare these treats as well as main dishes, vegetables and salads with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

Wesson satisfies the most exacting appetites. To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	19-28%
Total unsaturated	75-80%
Palmitic and stearic glycerides (saturated)	20-25%
Phytosterol (predominantly beta sitosterol)	0.4-0.7%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E.

HEART BEATS

(This material is provided by the Michigan Heart Association)

Honors Medical Students

Two Medical Student Research Fellows were honored at a luncheon on February 2 at the David Whitney House. F. D. Dodrill, M.D., Chairman of the Research Committee, presented the Michigan Heart Association Distinguished Achievement Award to Condon R. Vander Ark, junior medical student from Grand Rapids at the University of Michigan, and the Meritorious Achievement Award to Drake Duane, sophomore medical student from Detroit at Wayne State University.

Mr. Vander Ark worked with Ernest W. Reynolds, Jr., M.D., on "Experimental Study of the Origin of T Waves Based on Determinations of the Effective Refractory Period from the Epicardial and Endocardial Aspects of the Ventricle." Their paper was presented at the 32nd Scientific Session of the American Heart Association in Philadelphia last October.

Mr. Duane worked under Walter H. Seegers, M.D., Wayne State, and Jack Werboff, M.D., Lafayette Clinic, on "Changes in Cardiac Rate and Rhythmicity Due to the Repeated Hyperemotionality of an Avoidance Learning Program."

Donald S. Smith, M.D., Pontiac, President of the Michigan Heart Association stated that "student research is the keystone of our research program and lays the groundwork for future development of physicians interested in cardiovascular research."

New Education Materials Available

FILM: "Cerebral Vascular Diseases: The Challenge of Management" 16mm., 37½ minutes running time, black and white, sound.

Presents concepts and techniques basic to the management of persons who have suffered strokes. For physicians, nurses, medical students, hospital staffs, physical therapy specialists. (A companion film "CVD: The Challenge of Diagnosis" has been announced by the American Heart Association for availability this spring.)

SLIDE RESOURCE KIT: A collection of 192 slides which includes:

For Medical Audiences Only

Electrocardiogram Slide Set—119 b&w slides
Heart Drawings—3 color slides and legend
Heart Models and Cardiac Silhouettes—36 color slides

For Medical, Paramedical and Lay Audiences

Circulatory System—1 color slide
Coronary Circulation—1 b&w slide
Coronary Heart Disease—2 b&w slides
Development of Atherosclerosis—4 b&w slides

For Paramedical and Lay Audiences

Heart of the Home—21 color slides with script
Strokes—4 color slides

Course for Technicians

With the support of the Michigan Heart Association, the Anticoagulant Unit and the Department of Postgraduate Medicine of the University of Michigan Medical Center offer a five-day course in techniques in prothrombin testing. This program, providing individual instruction for one or two technicians at a time, is open throughout the year to individuals engaged in medical technical work. Laboratory and registration fees will be underwritten by the Michigan Heart Association. Travel and housing expenses are not covered and technicians should make arrangements through their employers.

Further information and application blanks may be obtained from: Medical Director, Michigan Heart Association, 3919 John R, Detroit 1, Michigan.

Circulation—Circulation Research

The American Heart Association and its affiliates have taken over an important new responsibility, publishing of the two outstanding scientific journals *Circulation* and *Circulation Research*.

Circulation which emphasizes clinical developments and *Circulation Research*, which emphasizes developments in cardiovascular research, are designed to bring the physician and medical scientist important developments in the cardiovascular field.

Subscriptions to either or both of these journals can be obtained by mailing the coupon below.

- -

TO: PUBLISHING DIRECTOR, AMERICAN HEART ASSOCIATION
44 EAST 23rd ST., NEW YORK CITY

Enclosed is a check for $..... for my 1960 subscription to (please check):

CIRCULATION ($14)..... CIRCULATION RESEARCH ($9)..... COMBINATION ($21).....

NAME .....

Address .....

City..... State.....

(Continued on Page 492)



Just one prescription for Engran Term-Pak
SQUIBB VITAMIN-MINERAL SUPPLEMENT *(270 tablets)*
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak. Engran is also available in bottles of 100 tablets.

SQUIBB *Squibb Quality—The Priceless Ingredient*
"ENGRAN"® AND "TERM-PAK"® ARE SQUIBB TRADEMARKS

New!

BAND-AID

TRADE MARK

Plastic Strips



- ELASTIC PLASTIC
- FLESH COLORED
- STAYS CLEAN
- THIN, SMOOTH PLASTIC
- GREASE RESISTANT
- WON'T WASH OFF

100's 1"x 3"
100's ¾"x 3"

Conveniently Located in Grand Rapids

- Hospital Equipment
- Pharmaceuticals
- Office Equipment
- Physicians' Supplies
- Trusses
- Surgical Garments
- Physiotherapy Equipment

MEDICAL ARTS

SUPPLY COMPANY
311 State Street, S.E. Phone GL 9-9413

PHARMACY
20-24 Sheldon, S.E. Phone GL 6-9661

DRIVE-UP PHARMACY
311 State Street, S.E. Phone GL 9-8294

Grand Rapids, Michigan

(Continued from Page 490)

Europe Bound Patients?

A list of physicians and laboratories in the following European countries may be obtained through the Michigan Heart Association for patients of Michigan physicians: Finland, Ireland, Italy, Norway, Poland, Portugal, Sweden, United Kingdom, and West Germany. The names of several cardiologists in any of the countries indicated can offer consultation, which might include a determination of prothrombin time.

Invite Memberships

The Michigan Heart Association invites all medical doctors to become active members in the Association. A five dollar membership includes automatic membership in the American Heart Association and the following dividends:

A one-year subscription to the following publications:

Modern Concepts of Cardiovascular Disease (issued monthly).
Heart Research Newsletter (issued quarterly).
The American Heart Quarterly
Challenge, Michigan Heart Association Newsletter (quarterly).
Admission to Scientific Sessions of MHA and AHA.
New Heart Literature.

Membership application and complete details may be obtained by writing to the Michigan Heart Association, 3919 John R, Detroit 1, Michigan.

Anticoagulant I.D. Cards

Identification wallet cards for persons on anticoagulant medication may be obtained in bulk quantities by physicians for distribution to patients.

In Lansing

HOTEL OLDS

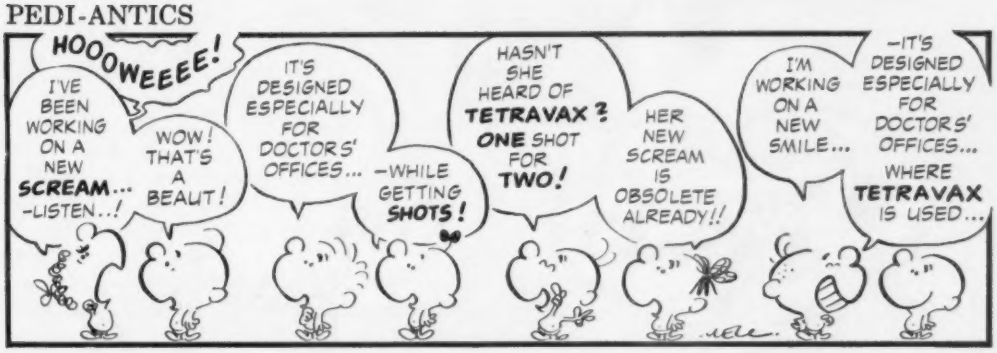
Fireproof

400 ROOMS

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

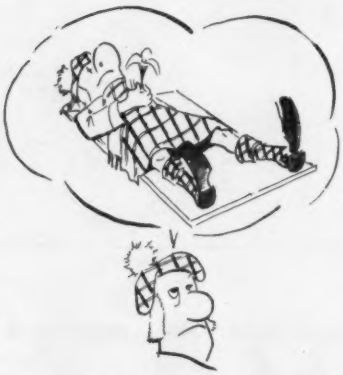
TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

C. A. Conshus, M.D., Says . . .



A dour canny Scot named
MacCropsie,
When his doctor suggested
biopsy,
Said, "Aye vurra weel,"
"We maun mak a deal
If it's cheaper than an
autopsy."



Our Mac is now hame i' the
glen,
A roamin the moor and the
fen.
Thanks to Dr. Macklusky,
And guid auld spey whusky,
He's playin his pipes once
again.



POINT - Skin
DANGER SIGNAL - Any change in a wart or mole.

Limericks by Sydney B. Carpender—Drawings by Robert Toombs.
Reprinted from the *Pennsylvania Medical Journal*, November 1957-October 1958. By permission of the Commission on Cancer, The Medical Society of the State of Pennsylvania and the American Cancer Society, Pennsylvania Division, Inc.

List Leading Causes of Death

Heart disease, cancer, strokes and accidents accounted for 71 per cent of all deaths in 1958, according to final data on 1958 mortality just released by the Public Health Service's National Office of Vital Statistics.

The 1,647,886 deaths that occurred in 1958 gave the nation a death rate of 9.5 per 1,000 population, compared to a rate of 9.6 in 1957. The number and the rates per 100,000 population for each of the four leading causes of death in 1958 follow:

	Number	*Rate*
Heart disease	637,246	367.9
Malignant neoplasms, of cancer	254,426	146.9
Vascular lesions (chiefly strokes)	190,758	110.1
Accidents, all forms	90,604	52.3
Motor-vehicle accidents	36,981	21.3
All other accidents	53,623	31.0

The death rates for heart disease and cancer in 1958, 367.9 and 146.9, respectively, were slightly lower than the comparable rates in 1957, 369.6 and 148.7. The rate for vascular lesions remained about the same.

The death rate for accidents, 52.3, was almost 7 per cent lower than the rate of 56.0 in 1957, with the percentage decrease being slightly lower for motor-vehicle accidents than for all other forms of accidents.

Chiefly as a result of the influenza epidemic of 1957-58, the toll of deaths from influenza and pneumonia remained high in 1958—57,439 deaths, or a death rate of 33.2 per 100,000 population.

OFFER SCHOLARSHIPS.—Scholarships to the Midwest Institute of Alcohol Studies, June 13-17, at the University of Wisconsin and the Yale Summer School of Alcohol Studies, June 26 to July 21, have been made available by the State Board of Alcoholism. The scholarship grants, designed for professional people interested in gaining a better knowledge of alcoholism, will include room, meals and tuition. Scholarship application may be sent to State Board of Alcoholism, 230 North Grand Avenue, Lansing.

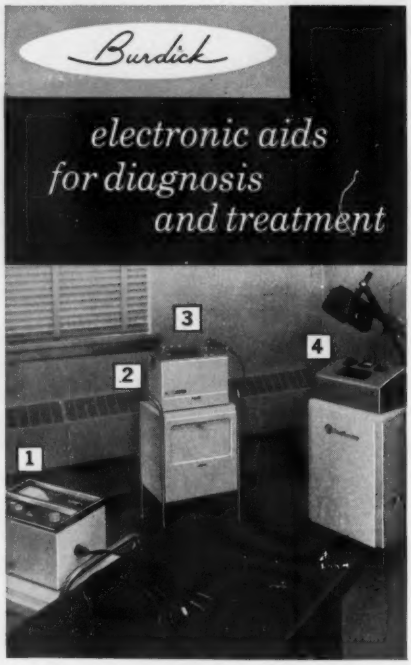
NUTRITION CONFERENCE.—The Sixth Annual Nutrition Conference will be sponsored by Wayne State University College of Medicine, Friday, March 18. Speakers on the general subject, "Prospects in Nutrition" will include Paul L. Day, M.D., of the U.S. Food and Drug Administration, Howard A. Schneider of the Rockefeller Institute, Paul L. White, M.D., of the American Medical Association, and James L. Wilson, M.D., of the University of Michigan. Members of the Michigan State Medical Society are cordially invited.

QUOTES MSMS JOURNAL.—The Council on National Defense of the American Medical Association in its Civil Defense Review, December, 1959, has a paragraph as follows:

"The Atom in Peace and War"

"The Journal of the Michigan State Medical Society devotes its October, 1959, issue to the atom as encountered in peace as well as in war. Michigan planning and the radiation effect on civil populations is discussed in articles on the destructive aspects of the atom while the use of radioisotopes in medicine and industry are considered in articles dealing with peactime applications. This national defense issue was prepared with the help and





With the advances and new technics in electronics as applied to medicine, efficient and practical equipment is now available for general office use—

1 **EK-III Dual-Speed ELECTROCARDIOGRAPH** — Lightweight, portable, accurate, simple to operate. 25 mm.- or 50 mm.-per-second speeds.

2 **UT-400 PULSED ULTRASONIC UNIT** — Continuous or pulsed energy. Compact, portable, six sq. cm. radiating area.

3 **MS-300 MUSCLE STIMULATOR** — Ideal for stimulation of innervated muscle tissue. Can be used in combination with the UT-400, as illustrated above.

4 **MF-49 SHORT WAVE DIATHERMY** — Versatile. Used with every type of diathermy electrode.

Complete information — including specifications and prices — on all Burdick electromedical apparatus is readily available from your local Burdick representative, or write directly to The Burdick Corporation, Milton, Wisconsin.

THE BURDICK CORPORATION
MILTON, WISCONSIN
Branch Offices:
New York • Chicago • Atlanta • Los Angeles
Dealers in all principal cities

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit 1, Michigan

direction of the Committee on National Defense of the Michigan State Medical Society. Single copies are available at a cost of sixty cents from the Society at 606 Townsend Street, Lansing 15, Michigan."

GRANTS OFFERED.—The research committee of the National Society for the Prevention of Blindness invites requests for research grants in 1960. Funds are available for projects that may contribute to basic understanding of eye function and pathology, or that may improve methods of diagnosis, treatment or prevention of blinding eye disease. Grants will be made this spring for requests received by April 1. Inquiries may be addressed to Research Committee, National Society for the Prevention of Blindness, 1790 Broadway, New York 19.

GRAND ROUNDS U-M MEDICAL CENTER.—Every Saturday, except holiday week ends, Grand Rounds will be held at the University of Michigan Hospital, 2nd floor, Amphitheater, Room 2450, 8:30 to 10:00 a.m. under Dr. Reed M. Nesbit in Urology; Dr. Cameron Haight in Thoracic Surgery; Dr. Edgar A. Kahn in Neurology and Dr. Carl E. Badgley in Orthopedics. All Grand Rounds are held under the general direction of Dr. Charles G. Child III, Professor of Surgery, and Chairman of the Department.

PSYCHIATRIC TELEVISION COURSES.—Under the sponsorship of the Wayne State University College of Medicine's Department of Psychiatry, and the Michigan Academy for General Practice, there will be given a fully accredited post-graduate course in psychiatry on television and FM radio. The television program will be given on the ultra-high frequency station of Wayne State University, WFVS, Channel 56, every Tuesday evening at 9:00 p.m., beginning Feb. 2. The program will last approximately an hour.

These programs will be re-broadcast each Thursday at 8:00 p.m., over the University's FM station (WDET—101.9 on the FM dial).

For information and registration, write the Registrar, 1806 Rivard Street, Detroit 7.

DR. THOREK DIES.—Dr. Max Thorek, seventy-nine, prominent Chicago physician, lecturer, author and teacher, died January 25, 1960, of a heart attack.

Dr. Thorek was founder of the International College of Surgeons and its Hall of Fame, founder and chief surgeon of Chicago's American Hospital, attending surgeon of Cook County Hospital, and professor of clinical surgery at the Cook County's graduate school of medicine.

He was a member of the National Academy of Medicine, Colombia, S.A.; National Gastroenterological Society, International College of Anesthetists, Royal Society of Arts, the American College of Gastroenterology, and the Royal Photographic Society of Great Britain.

He also was a member of the American Medical Editors and Authors Association, American Eugenics Society, German Medical Society, and the Chicago Historical Society.

Dr. Thorek was awarded honorary degrees by Lincoln Memorial University, Wesleyan College, the University

(Continued on Page 498)

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



Garden City, N. Y.



Lincolnwood, Ill.



Skokie, Ill.



Denver, Colo.



Denver, Colo.



No. Massapequa, L. I., N. Y.



Roselle, Ill.



Seaford, N. Y.



Hartford, Conn.



East Williston, N. Y.



Norwich, Vt.

DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply: Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

SQUIBB *Squibb Quality—The Priceless Ingredient*

"DELALUTIN"® IS A SQUIBB TRADEMARK

(Continued from Page 496)

of Istanbul, Turkey, and by many governments and educational institutions.

Dr. Thorek is survived by his widow, Fannie, and a son, Dr. Philip Thorek, Assistant Secretary General of the International College of Surgeons.

CONTINUES STUDY.—Edward F. Domino, M.D., Ann Arbor, will continue his study for a second year of the effects of drugs on the brain. The study is being financed by a grant of $10,422 from the United Cerebral Palsy Association to the University of Michigan Medical Center.

GETS CANCER GRANT.—William H. Beierwaltes, M.D., Ann Arbor, has received a grant of $2,000 from the Cancer Research Institute at the University of Michigan Medical Center for research titled "Antibodies to Thyroid Cancer."

U. P. CONFERENCE.—A Conference of Premature Infant Care for graduate professional nurses working in hospitals in the Upper Peninsula will be conducted at the Wallace Nurses Home, 400 West Magnetic Street, Marquette, Michigan, on April 19 and 20. The conference is being co-sponsored by the Michigan Department of Health and the Upper Peninsula Hospital Council. Information regarding this conference can be obtained from Goldie B. Corneliuson, M.D., Director Division of Maternal and Child Health, Michigan Department of Health, Lansing 4.

ON EDITORIAL BOARD.—Edward A. Carr, Jr., M.D., Ann Arbor, is a member of the editorial board of the new *Clinical Pharmacology and Therapeutics Journal.* The first issue of the new journal appeared in January.

ESTABLISHES U-M FUND.—James E. Lofstrom, M.D., Detroit, has contributed $500 to the University of Michigan to establish the Mr. and Mrs. George Niess Memorial Fund "to support research in the writings and career of Emile Zola with special reference to his relationships with impressionist painters."

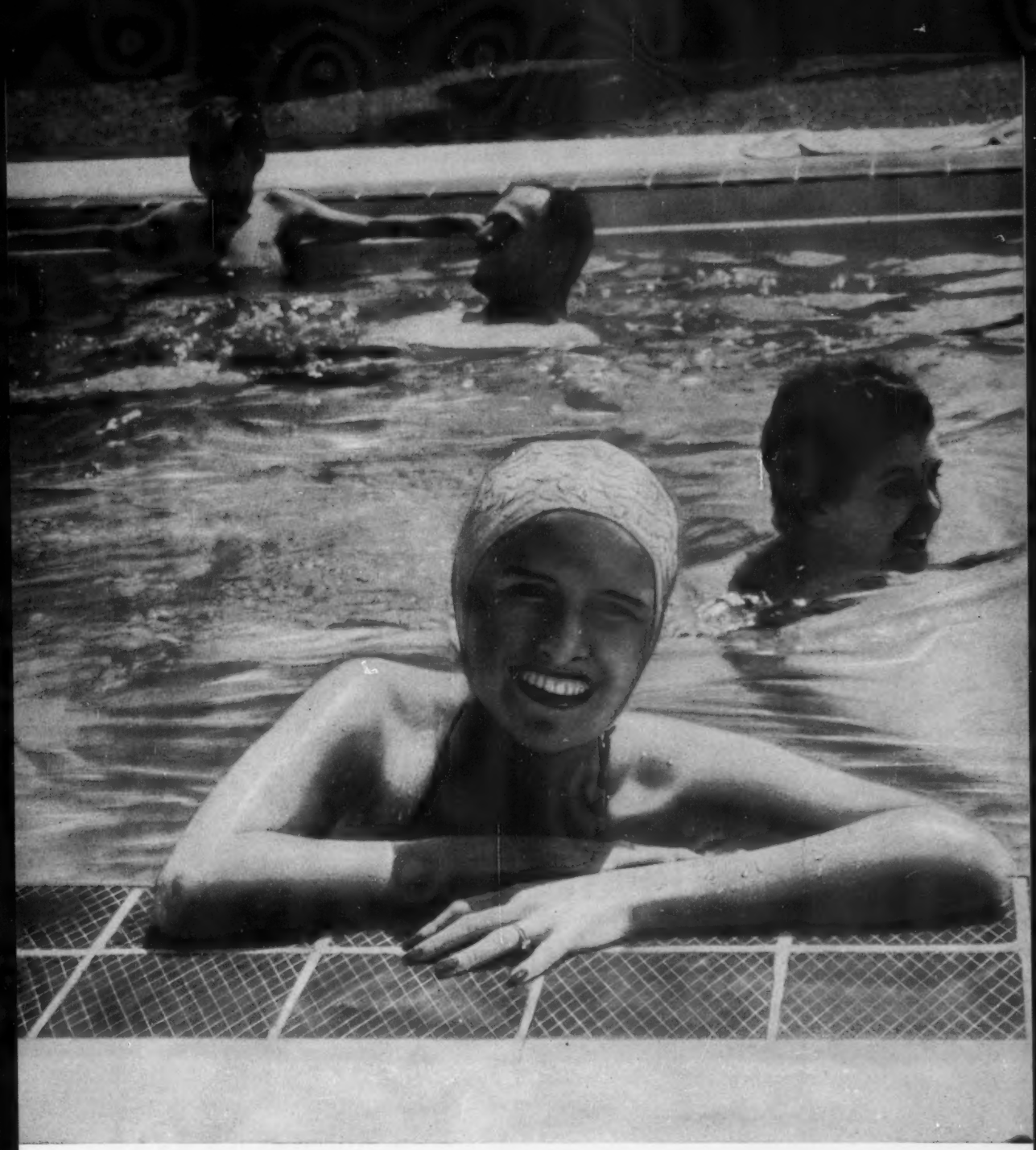
NEW FIFTY-YEAR CLUB.—J. H. McCurry, M.D., of Cash, Arkansas, advises that he has the approval of the American Medical Association to organize a Fifty-Year-Club within the AMA. Dr. McCurry is anxious to hear from physicians who have been in practice fifty years or more who desire to become members of this club, giving their name and a complete address.

The first meeting is to be held in Washington, D. C., at the Clinical meeting November 29 to December 2.

MEDICAL TELEVISION SHOWS.—The Michigan Health Council reports that the following topics were covered during January on the weekly Sunday morning program over WJBK-TV in Detroit: Medical Assistants, Preparing Your Child for School, Polio and The National Foundation, Cerebral Palsy, Heart.

(Continued on Page 500)





Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

5654

The most significant advance in analgesics since the isolation of morphine in 1805

Remarkable effectiveness and greater freedom from side reactions in the widest range of clinical applications

FOR PAIN

NUMORPHAN®

BRAND OF OXYMORPHONE, ENDO

"A NEW ERA IN PAIN RELIEF."

clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/more than 25,000 patients treated

SUPPLIED:

Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit 1, Mich.

*U. S. Pat. 2,806,033.

(Continued from Page 498)

OPHTHALMOLOGY DIPLOMATES.—From January 1, 1959 to January 1, 1960, the following Michigan physicians were granted recognition by the American Board of Ophthalmology:

Quentin P. Hamilton, M.D., Detroit; Conrad S. Heyner, M.D., Detroit; William T. Sallee, M.D., Detroit; John B. Burhans, M.D., and Dale F. Roth, M.D., of Grand Rapids. Roland L. Phillips, M.D., of Owosso.

E. L. COOPER SPEAKS.—Guest speakers at the University of Minnesota course on the diagnosis and treatment of strabismus included Edmond L. Cooper, M.D., Detroit. His topics were "Accommodative Esotropia," "Non-Accommodative Esotropia" and "Over-Correction in Muscle Surgery."

LEAVES MICHIGAN.—C. Thomas Flotte, M.D., Ann Arbor, will join the University of Maryland as an associate professor. Dr. Flotte came to Michigan in 1950 after serving as a Navy medical officer. He is well known in both professional and lay circles throughout Michigan. He has conducted medical courses in hospitals affiliated with the U-M Department of Postgraduate Medicine, and has been a frequent participant on the "Prescription for Health" broadcasts co-sponsored by U-M and MSMS.

NEW BOOK.—Creative clinical work and significant laboratory research in the areas of language disorders are revealed in a new publication by the National Society for Crippled Children and Adults. Written for professional workers, a long-term study of children with delayed speech and language is reported by Nancy E. Wood, Ph.D., Cleveland Hearing and Speech Center, in "Language Disorders in Children."

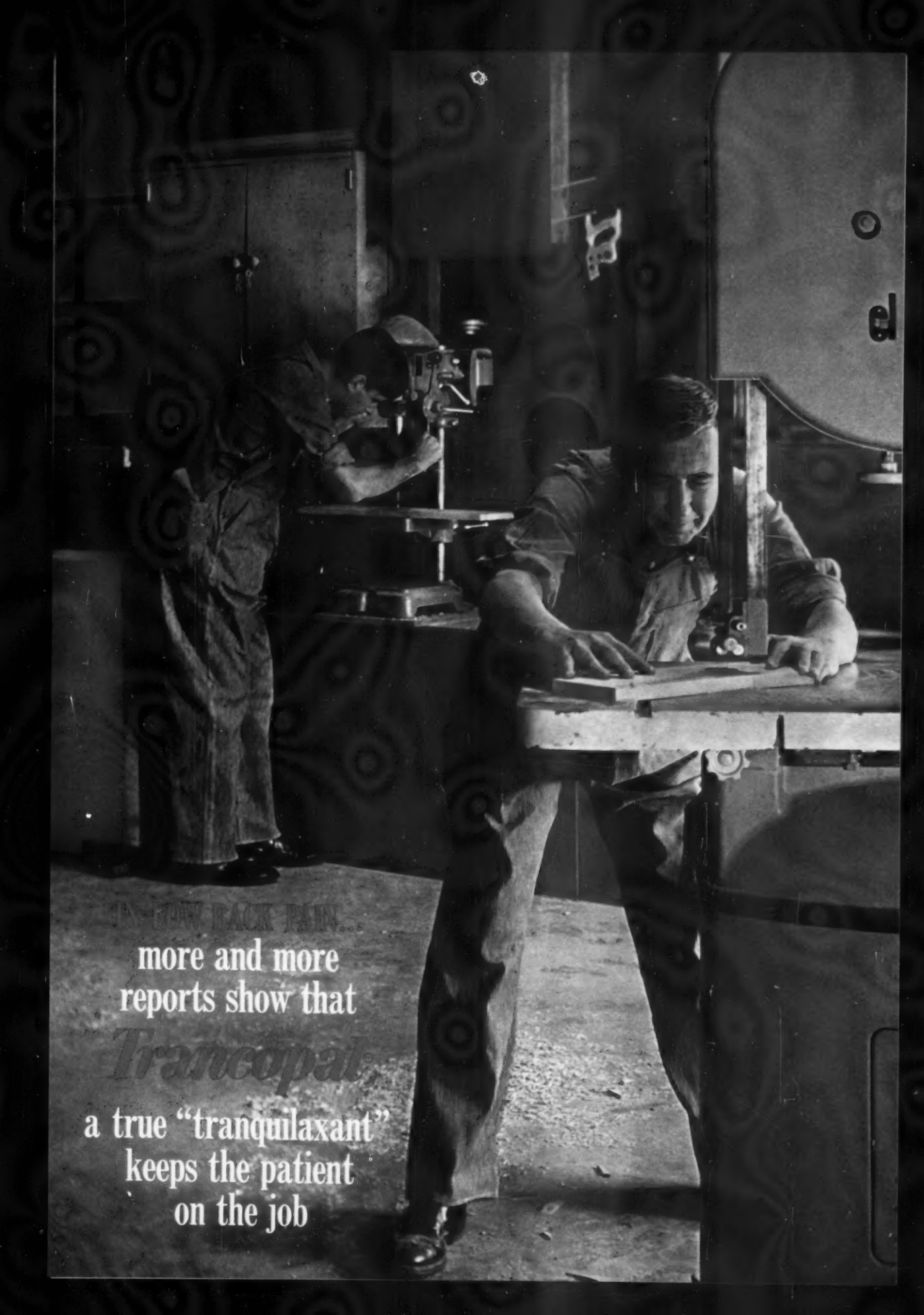
ATTENDS NATIONAL MEETING.—Roger B. Nelson, M.D., Ann Arbor, president-elect of the Michigan Hospital Association, attended the annual congress of the American College of Hospital Administrators in Chicago in February.

DETROIT M.D.'S HONORED.—Samuel G. Reisman, M.D., Detroit, is a new regional vice-president of Phi Lambda Kappa, medical professional fraternity, and Benjamin Brand, M.D., also of Detroit, is a new-elected trustee.

RECEIVES RESEARCH AWARD.—The Department of Dermatology at the University of Michigan Medical Center has won a top international award for research on psoriasis, a skin disease which occurs in a number of forms. The honor, called the J. N. Taub International Memorial Award for Psoriasis Research, carries a $1,000 grant to the winners, administered by Baylor University, Texas.

SPECIAL CAMP.—The Summer Camp for Diabetic Children will be conducted for the twelfth year by the Chicago Diabetes Association from July 17 through August 7, at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through fourteen years of age are eligible.

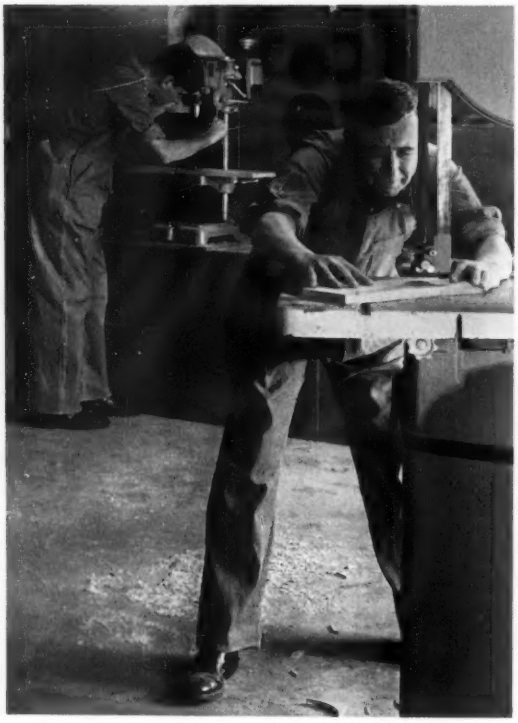
(Continued on Page 506)


more and more
reports show that
Trancopal
a true "tranquilaxant"
keeps the patient
on the job

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

Mullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] They found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome. (No side effects were noted except that one patient had slight dryness of the mouth.)

The pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.[7]

Trancopal is a true "tranquilaxant"

Trancopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, "...a most valuable drug for relieving tension, apprehension and various psychogenic states...allows the patient to use his energies in a more productive manner in overcoming his basic problems."[4]

(Continued from Page 500)

FOOD ADDITIVES BOOKLET.—A new Food and Drug Administration booklet entitled "What Consumers Should Know About Food Additives" has been published to answer the many questions people are asking about food additives and the new law. The booklet is for sale (15 cents) by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

DEDICATE U-M BUILDING.—The University of Michigan Medical Center formally dedicated a new $1½-million Mental Health Research Institute building in January. Major speakers were Detlev W. Bronk, M.D., president of the National Academy of Sciences, and Ralph W. Tyler, M.D., director of the Center for Advanced Study in the Behavioral Sciences.

The Institute has a staff of over sixty scientists—specialists in psychiatry and the social sciences—who are probing fundamental questions about human behavior. The new building is located at the west end of the U-M Medical Center.

M.D. LOCATIONS.—The current report of the Michigan Health Council includes the following information about doctor-placement activities:

Placed by Michigan Health Council—Frederick C. Reigle, M.D., Litchfield; Thomas J. Grause, M.D., Alpena.

Assisted by Michigan Health Council—John E. Finger, M.D., Ann Arbor.

MEDICAL MEETINGS U.S.A.

Thirteenth Annual Postgraduate Course on Diseases of the Chest, The Council on Postgraduate Medical Education of the American College of Chest Physicians, March 14-18, Sheraton Hotel, Philadelphia.

Advances in Urology, Postgraduate Course, March 16 and 17, North Clinic Building, Cleveland, Ohio; for information contact Education Secretary, Frank E. Bunts, Educational Institute, 2020 East 93rd Street, Cleveland 6.

Twelfth Annual Scientific Assembly, American Academy of General Practice, March 21-24, Convention Hall, Philadelphia.

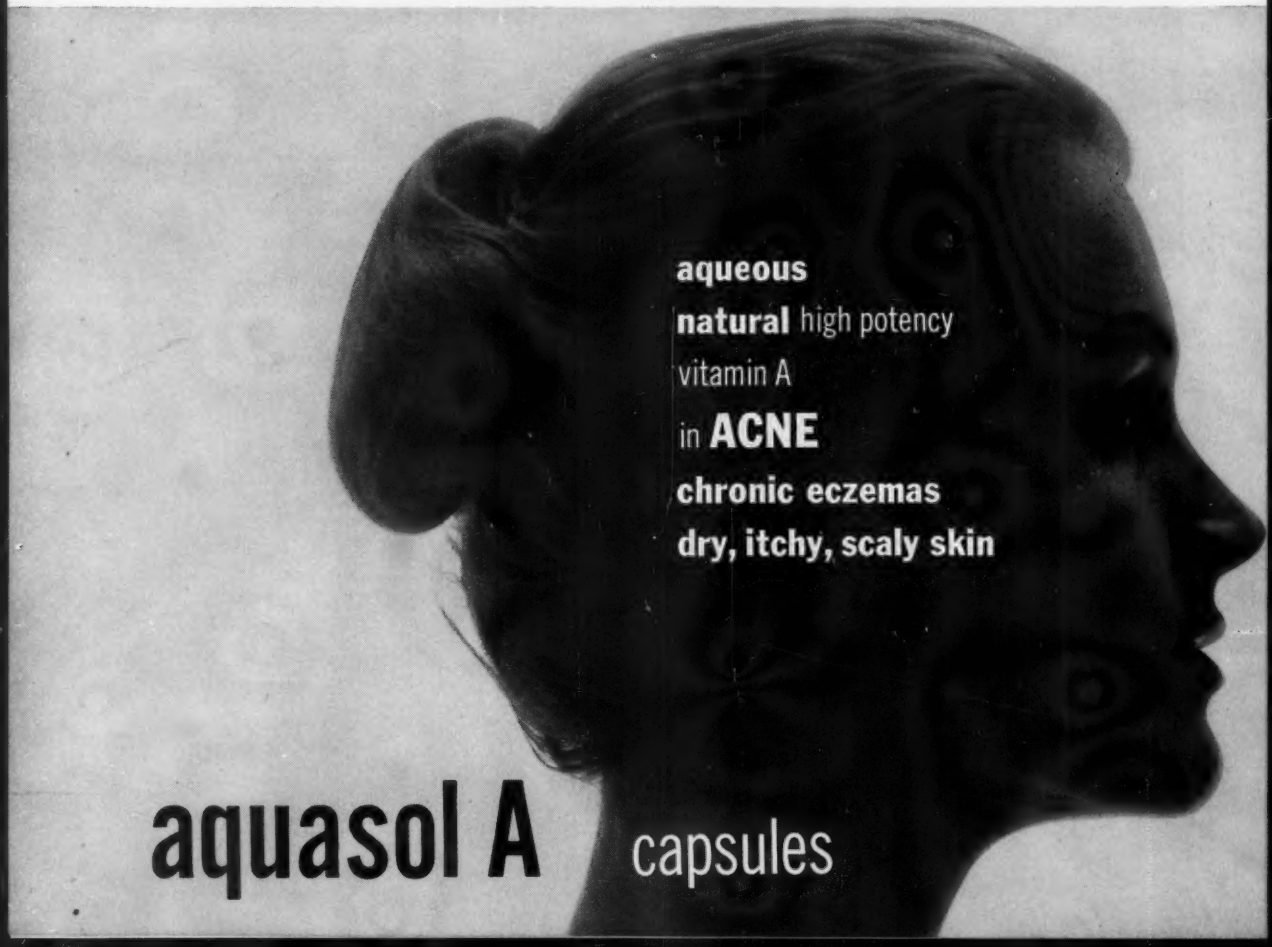
Clinical Reviews, Mayo Clinic and Mayo Foundation, April 4, 5, 6, Rochester, Minnesota; for information contact Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

The Industrial Health Conference (which includes the 25th annual meeting of the Industrial Medical Association), April 26-28, War Memorial Auditorium of Rochester, New York.

Fourth Postgraduate Course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, April 27-30, John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

Second International Symposium of the Deborah Hospital, April 28-30, Bellevue Stratford Hotel, Philadelphia.

The Student American Medical Association, May 5-7, Statler-Hilton Hotel, Los Angeles.



WSU OFFERS LECTURES—Wayne State University announces the tenth annual Leo M. Franklin Memorial Lectureship in the Human Relations series. The next number will be April 4 on "The Growth of Self Insight" by John M. Dorsey, M.D., professor and chairman, Department of Psychiatry, Wayne State University.

Through the courtesy of Station WDET, The Franklin Lectures will be rebroadcast on Thursdays at 7 p.m., beginning April 21. Other dates of the broadcast are: April 28, May 5, 12, and 19. The lectures will also be rebroadcast this autumn through the nationwide network of the National Association of Educational Broadcasters. Finally, they will be rebroadcast internationally through the Voice of America.

WAYNE BEGINS SERIES.—The first of a series of postgraduate courses in Internal Medicine at Wayne State University College of Medicine will be held April 27 and 28. The two-day course will be on "Cardiology."

WSU EVENT SET MAY 4—All Wayne University Medical School graduates are invited to attend the Annual Alumni Clinic Day, May 4, at the Fort Shelby Hotel, Detroit. The program will begin at 9 a.m. and conclude with an evening dinner and dance.

The Class of 1910 will observe its golden anniversary as one of the banquet highlights. Also, special awards will be given to the outstanding Sophomore student and the outstanding Senior student. Special recognition will be given to graduates or teaching staff members who have distinguished themselves in medical work.

The morning scientific program will begin at 9:30 and the afternoon scientific session will resume at 2 p.m. after the luncheon. The last series of scientific lectures will begin at 3:30 p.m.



Dean G. H. Scott (*left*) of the Wayne State University College of Medicine, accepts a $5,000 check from William H. Morgan, Wyeth Laboratories clinical associate. Center is Dr. Charles S. Stevenson, chairman, Wayne department of obstetrics and gynecology. The grant is one of twenty awards made annually by the Philadelphia pharmaceutical manufacturing firm to selected medical schools and hospitals. The recipients may use the funds for any purpose they desire.

aquasol A capsules

more readily, rapidly, completely reaches the affected tissues because there is "greater diffusibility of vitamin A from aqueous dispersion into the tissues."[1]

aquasol A capsules — the most widely used of all oral vitamin A products, for these good reasons . . .

aqueous vitamin A is more promptly, more fully, more dependably absorbed and utilized.

natural vitamin A is more effective because it is directly utilized physiologically.

well tolerated — fish taste, odor and allergens are removed by special processing.

economical — less dosage is needed and treatment time is sharply reduced as compared to oily vitamin A.

three separate high potencies (water solubilized natural vitamin A) per capsule:

25,000 U.S.P. units

50,000 U.S.P. units

100,000 U.S.P. units

bottles of 100, 500 and 1000 capsules

Samples and literature available upon request.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

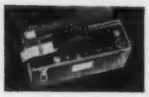
1. Davidson, D. D. and Sobel, A. E.: J. Invest. Derm. 12:221, 1949.

CAMBRIDGE

Cardiac Diagnostic Instruments

ASSURE THE DOCTOR OF

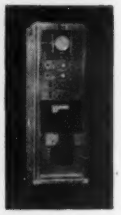
Universally Accepted Records, Fundamental Accuracy, Lifetime Dependability, Minimium Maintenance Expense.



"VERSA-SCRIBE" The Versatile Electrocardiograph

A completely new portable instrument with performance and versatility unsurpassed by any other direct-writing electrocardiograph. Size 5¼" x 10½" x 17", weight 20 lbs.

Multi-Channel Recorders



For physiological research, cardiac catheterization and routine electrocardiography. When used with pertinent transducers, these new Recorders provide simultaneous indication and recording of EKGs EEGs, stethograms and other physiological phenomena. Available in Photographic Recording and Direct Writing Models.



Dye-Dilution Curve Recorder

Records changes of concentration of a dye injected at selected sites in the venous circulation. Determines cardiac output; detects and locates cardiac shunts.

Operating Room Cardioscope



Provides continuous observation of the Electrocardiogram and heart-rate during surgery. Warns of approaching cardiac standstill. Explosion-proof. This cardioscope is a "must" for the modern Operating Room.



"Simpli-Scribe" Direct Writer Electrocardiograph

Provides the Cardiologist, Clinic or Hospital with a portable direct-writing Electrocardiograph of utmost usefulness and accuracy. Size 10⅜" x 10⅜" x 11": weight 28 pounds, complete with all accessories.

Audio-Visual Heart Sound Recorder

Enables simultaneous hearing, seeing and recording heart sounds. Recording may be made on magnetic discs for play-back and viewing at any time.



Pulmonary Function Tester

A completely integrated, easy-to-use instrument for the determination of such functions as Functional Residual Capacity, Tidal Volume, Vital Capacity, Total Lung Capacity, Total Breathing Capacity, Basal Metabolic Rate, etc

CAMBRIDGE ALSO MAKES EDUCATIONAL CARDIOSCOPES, PLETHYSMOGRAPHS, ELECTROKYMOGRAPHS, RESEARCH pH METERS, HUXLEY ULTRA MICROTOMES, POCKET DOSIMETERS AND LINDEMANN-RYERSON ELECTROMETERS.

SEND FOR DESCRIPTIVE LITERATURE

CAMBRIDGE INSTRUMENT CO., Inc.

Detroit 2, Mich., 7410 Woodward Avenue

Oak Park, Ill., 6605 West North Avenue
Cleveland 2, Ohio, 8419 Lake Avenue
New York, N. Y., 3732 Grand Central Terminal
Jenkintown, Pa., 479 Old York Road
Silver Spring, Md., 933 Gist Avenue
Pioneer Manufacturers of the Electrocardiograph

IN MEMORIAM

RICHARD A. BRUEHL, M.D., forty-eight, former Detroit physician, died January 9, 1960, at Port Charlotte, Florida, where he had resided since 1958.

Doctor Bruehl was graduated from the University of Michigan Medical School in 1937 and had practiced for many years in the Fisher Building, Detroit.

EARLE J. BYERS, M.D., seventy-four, Grand Rapids, died December 23, 1959.

Doctor Byers was born in Belvidere, Illinois. He was graduated with high honors from the University of Illinois Medical School in 1909 and was a member of Alpha Omega medical fraternity. He interned two years each at Passavant and St. Mary's Hospitals, both in Chicago, before beginning his practice in Grand Rapids in 1913.

He was a member of York Lodge No. 410, F & AM, DeWitt Clinton Consistory and Saladin Temple Shrine, and a member of Grace Episcopal Church.

CHARLES W. CASTROP, M.D., fifty-two, Dearborn, died January 8, 1960.

Born in New York City, Doctor Castrop moved with his family to Detroit in 1922. He attended the University of Detroit and was a 1931 graduate of the Wayne State University College of Medicine.

Doctor Castrop practiced for twenty-nine years in the Dearborn Medical Center and was on the staffs of Providence and Oakwood Hospitals.

He was a member of the Bishop Foley Council of the Knights of Columbus and was active in retreat work at the Passionate Fathers Monastery, Detroit.

DANIEL R. DONOVAN, M.D., sixty-seven, Detroit, died January 26, 1960.

Doctor Donovan was born and grew up in Detroit's old Corktown, where his father, the late Doctor Daniel O. Donovan, was a practitioner.

He attended the old Detroit College of Medecine (now Wayne State University) and went overseas in World War I with the 302d Medical Corps. He was awarded the Bronze Star during the Meuse-Argonne drive. After returning he joined the Veterans Administration, first at Marine Hospital and then on East Jefferson. In 1923 he entered private practice.

Doctor Donovan was the state athletic commissioner for nearly ten years.

In addition to being senior staff physician at Providence Hospital, Detroit, he was a member of Lodge No. 34, B.P.O.E., the Beaudry Post of the American Legion and St. Theresa's church.

PAUL WALTER DUBOIS, M.D., sixty-two- Detroit, died December 27, 1959.

Born in Brainerd, Minnesota, he received his medical degree from the University of Michigan in 1924. He interned at Harper Hospital and joined the staff in 1928.

Doctor DuBois was a member of the American College of Surgeons and the Detroit Athletic Club.

(Continued on Page 510)

Say you saw it in the Journal of the Michigan State Medical Society



Vernor's

GINGER ALE



Developed by Michigan's First Registered Pharmacist

•

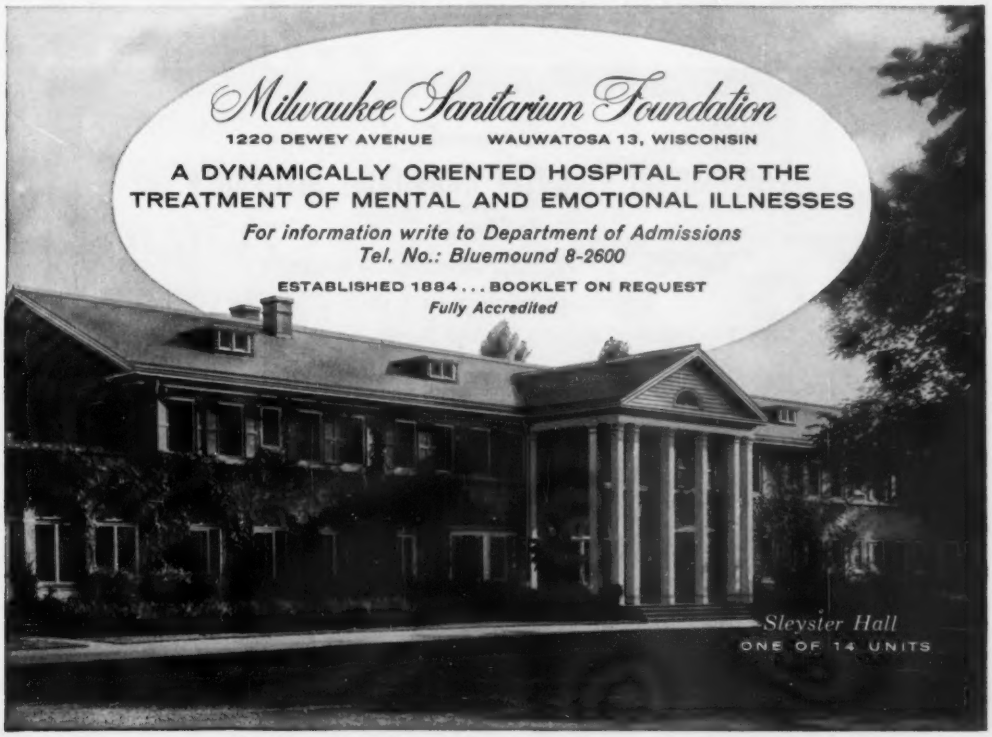
Recommended by Eminent Michigan Physicians

•

FLAVOR MELLOWED 4 YEARS IN WOOD

•

A PREFERRED BEVERAGE FOR HOME AND HOSPITAL



(Continued from Page 508)

EDWIN C. GANZHORN, M.D., sixty-eight, Ann Arbor, died January 17, 1960.

He was graduated from the University of Michigan Medical School in 1915 and practiced general medicine for forty-five years.

In 1920 Doctor Ganzhorn was elected coroner for Washtenaw County. He held this post for forty years.

WILLIAM GRAMLEY, M.D., seventy-two, Grosse Pointe, died January 7, 1960.

A native of Pennsylvania, Doctor Gramley was a graduate of the University of Michigan Medical School and did graduate work at Harvard Medical School. He practiced in the Wayne County area for over forty-five years.

He served as a Captain in the Medical Corps in World War I, was a member of the American Legion Post No. 126, Fine Arts Society and Oakland Hills Country Club.

JAMES A. J. HALL, M.D., seventy-nine, Detroit, died January 15, 1960.

A native of West Bloomfield, N. Y., Doctor Hall was a University of Michigan Medical School graduate. He practiced in Detroit for more than fifty years, and was a staff physician at Grace Hospital.

He was a member of Corinthian Lodge, No. 241, F & AM.

FORDUS V. HAND, M.D., fifty-three, Grosse Pointe Park, died December 23, 1959.

Born in Paulding, Ohio, he was a 1933 graduate of the University of Michigan Medical School and was on the staff of Deaconess Hospital. His offices were located in the Kirby Medical Center.

Doctor Hand was a lieutenant commander in the Navy during World War II; a member of Temple Lodge 501, F & AM; and the Moslem Temple.

SIMON E. LERMAN, M.D., forty-seven, Warren, died January 14, 1960.

A native of South Bend, Indiana, Doctor Lerman received his pre-medical training at Notre Dame University and his medical degree from the University of Michigan in 1939. He was the organizer of Memorial Clinic in Warren.

Doctor Lerman was a member of Yeshivath Beth Yehuda, Louis Marshall Lodge of B'nai B'rith; Knights of Pythias; and a philatelic club.

MARK F. OSTERLIN, M.D., fifty-six, Traverse City, died January 26, 1960.

Doctor Osterlin was born in Norwalk, Ohio. He received his A.B. degree in 1925 from Capital University and his medical degree at the University of Michigan in 1929, where he was instructor in pediatrics and communicable diseases. In addition to his teaching duties at Ann Arbor, he was director of the Central Michigan Children's Clinic in Traverse City.

He was a member of the Bethlehem Lutheran Church, Traverse City.

CHARLES H. PEABODY, M.D., eighty-three, former Lake Odessa practitioner for fifty years, died December 25, 1959.

A native of Mulliken, he was graduated from the Toledo

"Approved"

PROFESSIONAL LIABILITY INDIVIDUAL INSURANCE

by

The No. 1 Malpractice Insurer *

*MEDICAL ECONOMICS, FEB. 3, 1958

Unparalleled Experience • Specialized Service • Saving in Cost

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT, OFFICE:
George A. Triplett and Richard K. Wind, Reps.
2405 West McNichols Road Tel. University 2-8064

Medical College in 1898 and started his practice in Mulliken.

Doctor Peabody retired from active practice in 1948 at which time he was presented a plaque on behalf of the village residents and an open house was held in his honor at the school building. Following his retirement he served his community in an advisory capacity before moving to Youngstown, Ohio, to be near his son, Doctor Cary Peabody. A brother, Doctor Guy Peabody, resides in Toledo, Ohio.

At the sixteenth annual Mulliken fair the theme of the parade was based on the life of this doctor. In a special ceremony he was presented a plaque by Governor Williams for his service to the community.

Doctor Peabody was a member of the Lions Club and the Masonic and I.O.O.F. Lodges.

COMMUNICATIONS

MSMS Journal Editor:

Do you have reprints of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY—May, 1957, Vol. 56, No. 5?

We would appreciate receiving six copies of this issue if they are available for the use of our Wayne State University Occupational Therapy students.

Sincerely,
BARBARA JEWETT, OTR, *Director*
Wayne State University, Department Occupational Therapy, 261 Brady, Detroit 1, Michigan

Laboratory Examinations
Tissue Diagnosis

Allergy Tests
Autopsies
Bacteriology
Basal Metabolism
Chemistry
Electrocardiograms
Hematology
Papanicolaou Stain
Pregnancy Tests
Protein Bound Iodine
Urinalysis
Serology—Kahn and Wassermann

CENTRAL LABORATORY
Oliver W. Lohr, M.D., *Director*
537 Millard Street
Saginaw, Michigan
PHONE: Pleasant 2-4100
2-4109

WELCH ALLYN
LIGHTS THE WAY

NEW ROTATING ANOSCOPE

Facilitates examination and instrumentation



- Speculum can be rotated without moving handle. Simple mechanism turns speculum through full 360°.
- Orbiculated edges minimize discomfort as speculum is rotated even in the presence of rectal pathology.
- Entire instrument can be autoclaved or boiled, including the light carrier and lamp.
- Brilliant self-illumination with durable Welch Allyn No. 2 lamp.

No. 288 ANOSCOPE with Light Carrier $27.50
Fits Standard Welch Allyn Battery Handles.

NOBLE-BLACKMER, INC.
267 W. Michigan Ave. Jackson, Mich.

Say you saw it in the Journal of the Michigan State Medical Society

Michigan Authors

Martin J. Urist, M.D., South Haven, "Primary and Secondary Deviation in Concomitant Squint," *American Journal of Ophthalmology*, November, 1959.

J. S. DeTar, M.D., Milan, **W. B. Hildebrand, M.D.,** Menasha, Wisconsin, "The Relationship Between the General Practitioner and the Specialist," *Minnesota Medicine*, November, 1959.

Richard E. Straith, M.D., Detroit, "Correction of the Protruding Ear," *Plastic and Reconstructive Surgery*, September 1959.

Clair E. Laidig, M.D., and **James M. Pierce, Jr., M.D.,** Detroit, "Retrocaval Ureter—Unusual Cause of Ureteral Obstruction," *Journal of the American Academy of Medicine*, December 26, 1959.

Kenneth R. Magee, M.D., Ann Arbor, "Myasthenia Gravis: Its Diagnosis and Treatment," *Clinical Medicine*, December, 1959.

Albert C. Furstenberg, M.D., Ann Arbor, "Symposium Are We Good Teachers? Summation for Otolaryngology," *Transactions, American Academy of Ophthalmology and Otholaryngology*, November-December, 1959.

Leonard F. Bender, M.D., Ann Arbor, "Philosophy of Rehabilitation," *Industrial Medicine and Surgery*, January, 1960.

Max Karl Newman, M.D., Detroit, "Physical Medicine and Rehabilitation in Law-Science: Its Value in Personal Injury Problems and Medicolegal Trial Technics," *Archives of Physical Medicine and Rehabilitation*, January, 1960.

George J. Moriarty, M.D., Aaron A. Farbman, M.D., Laurence M. Linkner, M.D., and **Garnet T. Ice, M.D.,** Detroit, "Gems and Stratagems I, 1959 Meeting, American College of Surgeons," *Harper Hospital Bulletin*, November-December, 1959.

Frederic C. Schreiber, M.D., Detroit, "Surgical Gambits," *Harper Hospital Bulletin*, November-December, 1959.

Henry K. Schoch, M.D., Ann Arbor, "Research and the Resident Physician," *University of Michigan Medical Bulletin*, November, 1959.

George E. Block, M.D., Robert P. Singer, M.D., and **Charles W. Porter, A.M.,** Ann Arbor, "Progesterone Excretions of Patients with Advanced Carcinoma of the Breast," *University of Michigan Medical Bulletin*, November, 1959.

Roy Patterson, M.D., Ann Arbor, "Allergic Emergencies," *The Journal of the American Medical Association*, January 23, 1960.

It's an "OPEN AND SHUT CASE" for sandura

The new WELCH ALLYN instrument case that offers you far greater

- **DURABILITY**
- **CLEANLINESS**
- **COMPACTNESS**
- **BEAUTY**



ILLUSTRATED— Welch Allyn Otoscope-Ophthalmoscope Set No. 983, complete with Sandura Case.

The Sandura Case is molded in reinforced material to stand great shock or abrasion, with tarnish-proof soft rubber lining which protects instruments from shock. The entire case can be washed or sterilized with alcohol.

THE MEDICAL SUPPLY CORPORATION

OF DETROIT

3632 Woodward Avenue **TEmple 1-4588 TEmple 1-4589** **Detroit 1, Michigan**

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Prescribe

PEDAMETH®

(dl-methionine DURST)

WAYS TO SAVE MORE LIVES NOW





Cancers of the breast, cervix, and rectum . . . three common and too frequently fatal sites of cancer . . . can often be controlled through early detection and proper treatment. The methods and means are available *now*. Yet many more cures in these sites could be effected than are now being achieved.

The American Cancer Society, in its broad public education program, emphasizes the importance of an annual health examination for all adults. It also brings to physicians information on the value of regular examination of the breasts, the routine "Pap" smear, and the proctoscopic examination, to save lives from cancer.

An alerted public and medical profession can win a major victory over cancer . . . *now*.

AMERICAN CANCER SOCIETY®

EDITORIAL COMMENT

Medical Care vs. Doctor Care

New York State Journal of Medicine,
February 15, 1960

As discussion of legislation in relation to care of the sick commences in the first year of the new decade it is probable that the publicity relating to it will repeat the errors of former years.

We refer to the indiscriminate use of the terms "medical care" or "medical services" when those services rendered by doctors only are referred to. Why is this important? It is important because people are prone to forget that no one but a physician can give them "doctor care."

On the other hand, "medical care" is a broad term. It includes the services of hospitals, nurses, medicines, dentists, and paramedical technicians, to name but a few.

So when the political orators begin again to bring up the costs of "medical care," let those costs be broken down in such a way that the public knows what "doctor care" as opposed to "medical care" in general is costing them.

If this is done, it may surprise many to know that out of what is called "the medical dollar" the physician receives somewhat less than twenty-five cents. During the past ten years doctors' fees have not increased in proportion to the other items included in the cost of living index.

Doctor vs. Quack

Detroit News, December 18, 1959

The question has arisen of late as to whether the sale of fake cures for all sorts of maladies, from cancer to baldness, does not constitute the criminal offense of obtaining money under false pretenses.

We are not speaking here of poisons in foods, possibly harmful additives, adulteration of products, fake nutritional claims or any of the other practices or conditions outlined by our J. F. Ter Horst in Sunday's Passing Show section of The News. The reference is to the $12 million a year fraud practiced on arthritis

(Continued on Page 516)



Cough Control

. . . combined with Phagocytic stimulation

USE AQUEOUS GUAIAFAGE

Rapidly effective in all upper-respiratory infections where ventilation by expectoration is necessary. Available only in 30 cc vials.

MEYER & COMPANY

Ethical Pharmaceutical Manufacturers
22601 MACK AVENUE . ST. CLAIR SHORES, MICH.

Say you saw it in the Journal of the Michigan State Medical Society



BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

A facility designed to rehabilitate or to aid the addict in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of U. S. 16 at Kensington Road
Brighton, Michigan
ACademy 7-1211

Established 1924

MERCYWOOD SANITARIUM

Conducted by Sisters of Mercy

Treatment for Emotional and Mental Disorders

Medical Staff
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.
Stephen C. Mason, M.D.

JACKSON ROAD
ANN ARBOR, MICHIGAN
NOrmandy 3-8571

Plainwell Sanitarium

PLAINWELL, MICHIGAN

Member American Hospital Association

EDWIN M. WILLIAMSON, M.D.
Psychiatrist-in-Chief

Professional care for the nervous and mentally ill.

Telephone MUrray 5-8441



Restful Six-acre Estate Overlooking the Kalamazoo River



HOW FIRM A FOUNDATION...

...does a crippled child need?

Faith, of course, in those who love her, guide her care and treatment, plan her future. Hope, that some day—perhaps not too far away—crutches and braces will become a memory. Confidence, that her tomorrows will be happy, rich in usefulness and opportunities.

Such firm foundations can be —and have been—built through Easter Seal services since 1921. Thousands have found independence because of the constantly expanding nationwide program of the Easter Seal societies.

Share in building these firm foundations. Send a check today.



Donations will be gratefully received at the headquarters for the Michigan Society for Crippled Children and Adults, 10601 Puritan Avenue, Detroit 38, Michigan.

Doctor vs. Quack

(Continued from Page 514)

sufferers—and the whole field of allied quack medicine promotions—as related by Merle Oliver in The News.

One of the "miracle cures" for arthritis, for example, is a liquid with a tequila base, sold apparently on the theory anything tasting as bad as it does must have curative properties. Tinted alcohol flavored with cactus juice is another favorite.

The persons paying extravagant prices for these products are being defrauded just as surely as are widows robbed of their life savings by the "pigeon drop" racket. But the con man is likely to wind up in jail. The quack medicine swindler is not.

The reason is that no matter how preposterous the medical claims for a product may be, there always are persons who will testify they have been benefited. They forget that any pill may be of temporary psychological help, or that in many maladies the pain comes and goes even without medicines. Their testimony makes convictions almost impossible to obtain.

There is, however, one sure way to put the quacks out of business. It is to consult one's doctor, local medical society or Better Business Bureau. And it is a procedure which, perhaps, the doctors and medical societies should do more to encourage.

Medical Care Dollar Is Still a Good Investment

Clinton County Republican News, October 30, 1959

Attacks by some prominent doctors on the Blue Cross M-75 care plan at the recent meeting of the Michigan State Medical Society in Grand Rapids focus attention on the economics of medical care.

All of us gripe about the rising costs of hospital care and doctors' bills. It frequently happens they hit us "when we are down," and seem worse than other rising costs of living. We can't afford to be sick, nor can we very well afford at times the preventive examinations and medicines.

BUT FOR THOSE who will heed, there is a silver lining. We live longer, stay well longer and get really sick less often than in days of yore.

There is better sanitation, and general working conditions have improved that were a danger to health, and much sickness is prevented rather than endured. More sick people get well, and get well quicker than in the "good old days."

It is said modern medicine, surgery and drugs have added seven years to the average life span since 1940. They have reduced the average length of hospitalization by more than 16 days in the past 20 years, and made rapid cures possible in thousands of cases without going to a hospital.

THERE SEEMS to be a more or less wide-spread feeling that medical care costs have out-run general price increases. But for the sake of fair comparisons, in the 20 year 1938-58 period the consumer price index rose 104.8 per cent. Medical care costs rose 99.2 per cent. And physicians' fees rose 83.9 per cent.

These figures were presented by E. F. Hutton in writing recently in the *Houston Chronicle* on the economics of medical care.

Statistics aside, how much are seven more years of life worth? How much is health worth? How much is speedy and complete recovery from illness worth? Such questions are impossible to answer in terms of money. The medical care dollar still seems to be a good investment.

Point to Examine In Aiding Oldsters

Detroit Free Press, December 23, 1959

A 1960 legislative program in the field of public assistance has been outlined by Arthur S. Flemming, Secretary of Health, Education and Welfare.

After pointing out that 53 per cent of public assistance money is now channeled through the Federal Government, Flemming said he would ask Congress for a "positive plan" for medical care for recipients of old age and survivors' benefits.

He also said he would propose a Federal program for independent self-care for the infirm and severely

handicapped, and called for research on social problems that make persons dependent on public welfare.

Although Flemming said his program would aim at cutting costs, he made several suggestions that would increase expenditures on programs that already are often criticized as responsible for encouraging a completely non-productive kind of citizen.

Among these, for instance, was a proposal to grant aid to dependent children on the basis of need only, regardless of whether a father or what Flemming called a "father figure" is in the home.

Most States cut off ADC funds if an employable man is living in a household. If Flemming's recommendation becomes law, there will be further dilution of individual responsibility for the support of children.

Flemming's promise of a "positive plan" to provide medical assistance for the aged is, of course, in answer to the Forand Bill, which he opposed and which failed to get Congressional approval during the last session.

The bill would have provided medical care, backed by a payroll tax, for those receiving old-age benefits.

Whatever needs to be done to ease the burden of those older persons who cannot afford medical care, much consideration should be given the assistance form in order that the widely-known abuses of other public assistance programs would be, as far as is possible, excluded.

Perhaps Flemming's proposed research on what makes people dependent on public assistance will reveal whether the Government's rules and regulations, themselves, contribute to the often personally-unwanted dependence of ever-increasing numbers of people.

"Federal taxes in Michigan for fiscal 1959 were slightly over $5 billion or about $1.2 billion less than the preceding year. The total amount of federal taxes collected for all the states in fiscal 1959 amounted to almost $79.8 billion which makes Michigan's contribution 6.28 per cent of the total. In fiscal 1958, Michigan's share was 7.75 per cent of an $80 billion total. This is the third consecutive fiscal year that total federal taxes for Michigan have shown a decrease from the all time high of $7 billion in fiscal 1956."—Michigan Department of Revenue, *Research and Statistical Bulletin*, Vol. XXII, No. 3.

* * *

Since 1901, when the Nobel prizes in medicine were first granted, America's medical men have captured twenty-seven out of the seventy-six medals that have been awarded. Most recent recipients are Dr. Severo Ochoa of New York University's College of Medicine and Dr. Arthur Kornberg of Stanford University—again Americans. They were honored for their work in synthesizing ribonucleic acid and desoxyribonucleic acid.

...MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?
OUTMODED AS GODEY'S FASHIONS!

℞ NEW
PRENALIN-O®
PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

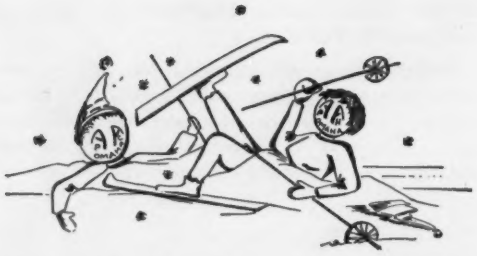


EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG
S. J. TUTAG & CO.
DETROIT 34, MICHIGAN



Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book sent to you FREE upon request.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- **the most modern, coordinated, comprehensive, rehabilitative regimen**
- **in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy**
- **full cooperation throughout with the referring physician**
- **in addition to the care of the alcoholic we also treat narcotic and drug addiction**
- **surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine**

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty.

FOR RENT—Three-room suite in new medical building for general practitioner. Location ideal—one hour from Detroit. Growing community. For further details contact W. C. Gibson, M.D., 216 E. Commerce Street, Milford, Michigan. Phone Milford, MUtual 4-6775 and MUtual 4-6771.

FOR SALE: Excellent general practice in Michigan small city with good hospital. Mostly new furnishings and equipment. Self-owned office in very good condition which could accommodate two doctors. Good parking facilities and excellent location. Much better than average records. Has to be seen to appreciate all advantages. Reply Box 9, 606 Townsend Street, Lansing 15, Michigan.

RETIRED PHYSICIAN wanted to conduct the medical program in the Detroit House of Correction located in the vicinity of Detroit, caring for male and female inmates. Work routine not overtaxing and well suited to the needs of retired person. Pay rate between $9,100 to $10,300 per year. Residence might be furnished if required. Apply in detailed letter furnishing curriculum vitae and photograph. Send reply care of Superintendent Albert Shapiro, Detroit House of Correction, Plymouth, Michigan.

MICHIGAN LICENSE, American graduate, General Medical Resident duties at 100-bed Detroit hospital. $1,000 month. Family living quarters available. Photograph and particulars. Reply Box 8, 606 Townsend Street, Lansing 15, Michigan.

WANTED: Physician-Surgeon preferred, or Physician, to ESTABLISH OWN INDEPENDENT PRACTICE in city of Wakefield, Michigan, approximately 3,400 population. Located in Gogebic County, near western part of Upper Peninsula. Modern fully equipped office, with two-bedroom, unfurnished apartment above, or four-bedroom dwelling next door, for sale, near new 60-bed hospital. Contact City Clerk, Wakefield, Michigan, for particulars.

AVAILABLE: Mayo-trained general surgeon, age 34, married, M.S. in surgery, trained in all phases of general surgery including vascular and thoracic, desires association with a group or a clinic in Michigan. Michigan license. Reply Box 7, 606 Townsend Street, Lansing 15, Michigan.

MICHIGAN DEPARTMENT OF MENTAL HEALTH is interested in obtaining additional staff physicians who are willing to accept the challenge of providing the best medical treatment available for its charges. Excellent opportunities for energetic, talented, ambitious medical doctors. Clinical supervisory positions as well as administrative positions available to those who meet the necessary qualifications. Salary to $18,884 depending upon qualifications. Many job benefits, including sick and annual leave, retirement, longevity compensation as well as merit increases. For further information, contact V. A. Stehman, M.D., Deputy Director, Cass Building, Lansing, Michigan.

FOR SALE: General practice, lucrative home-office combination, good hunting, fishing and winter sports area. Office equipment, records and drugs. Owner leaving for health reasons. Good, modern hospital within eleven miles. Contact: Ralph Lommen, M.D., Manton, Michigan.

For Men, Women and children
501 Mutual Bldg.
28 W. Adams

HACK'S FOOT NOTES

Shoe Information for the Profession
PUBLISHED BY THE HACK SHOE CO.

Children's Branches
19360 Livernois
and
16633 E. Warren

WE'VE TAKEN THE FIFTH!

Not the 5th Amendment nor a fifth of Scotch—but the entire 5th Floor of the Mutual Building!

Continuous growth since 1916 has necessitated periodic expansion, and recently we took over the entire 5th Floor—with the space divided between the Ripple Sole Corporation and its parent, the Hack Shoe Company.

We owe our growth to your *understanding*.

Index to Advertisers

Abbott Laboratories....372, 390
American Cancer Society....494, 513
Ames Co., Inc....Cover III
Ayerst Laboratories....499
Barry Laboratories....398
Bayer Co....393
Brighton Hospital....515
Bristol Laboratories....366, 367, 368, 369, 412
Burroughs Wellcome & Co....Insert (391, 392)
Cambridge Instrument Co....508
Central Laboratory....511
Central Pharmacal Co....394
Ciba....365, 385
Classified Advertising....518
Coca-Cola....384
Columbus Pharmacal Co....356
Desitin Chemical Co....414
Durst, S. F., & Co., Inc....513
Endo Laboratories....409
Geigy....388, 480
General Electric....386
Hack's Foot Notes....519
Haven Sanitarium....486
Hotel Olds....492
Ingram, G. A. Co....496, 500
Keeley Institute....518
Lederle Laboratories....Insert (357-364), 383, 402, 438-B, 438-C, 481
Lilly, Eli, & Co....416
Medical Arts Supply Co....492
Medical Protective Co....510
Medical Supply Corporation....512
Merck, Sharp & Dohme....350, 493, 505
Mercywood Sanitarium....515
Meyer & Co....514
Milwaukee Sanitarium Foundation....509
National Society for Crippled Children and Adults....516
Noble-Blackmer, Inc....511
Ortho....389
Parke, Davis & Co....Cover II, 349
Pfizer Laboratories....371, 438-D, 487, 520
Physicians Casualty & Health Associations....518
Plainwell Sanitarium....515
Professional Management....519
Robins, A. H., Co....370, 405
Roerig....387, 400, 401, 411
Sammond Pleasant Lodge....406
Sardeau, Inc....482
Schering Corporation....397, 415, 498
Searle....477
Smith-Dorsey....399
Smith, Kline & French Laboratories....Cover IV
Squibb....407, 438-A, 478, 479, 491, 497
Tailby-Nason Co....408
Testagar & Co....353
Tutag, S. J., & Co....517
Upjohn....354, 355
U. S. Vitamin Corporation....506, 507
Vernor's Ginger Ale....509
Wallace Laboratories....Insert (373, 374), 375, 413
Wesson Oil Co....488, 489
Winthrop Laboratories....381, 410, Insert (501-504)

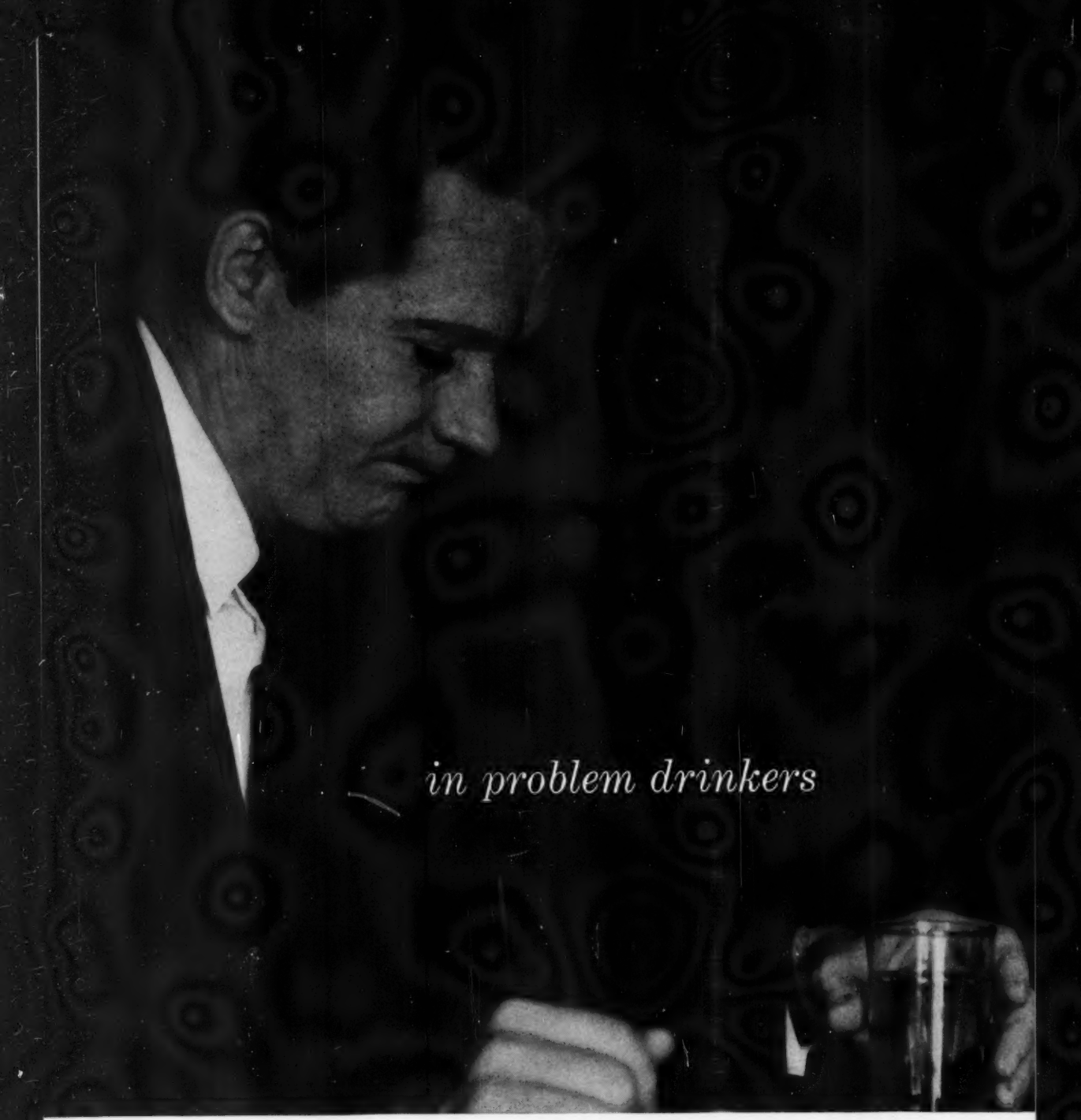
PROFESSIONAL MANAGEMENT • FOR PHYSICIANS AND DENTISTS
since 1932 PM®

Battle Creek WO 5 5253
Detroit WO 1-6259
Grand Rapids GL 6-1781
Saginaw SW 2-7661

TESTED — Rx — APPROVED
By
Professional Management
THE NEW PM WRITING BOARD

ONE WRITING ONLY

Produces a receipt
Provides an up-to-date statement
Posts the patient's account
Permits photo-type statements
Makes the day book record
Minimizes bookkeeping



Vistaril®

hydroxyzine pamoate

dispels tension...
maintains tranquility

When tension and anxiety "drive him to drink," the problem drinker often finds that VISTARIL, by maintaining tranquility, restores perspective and helps him accept counsel more readily.

VISTARIL has demonstrated a wide margin of safety even in large doses (300-400 mg. daily) over prolonged periods. Clinical studies of alcoholism have shown that VISTARIL produces no significant depression of blood pressure, pulse rate, or respiration in chronic drinkers.

Capsules—25, 50, and 100 mg. *Parenteral Solution* (as the HCl)—25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules.

Professional literature available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, New York

Pfizer *Science for the world's well-being*™



AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE

WHY IS DIABETES IN INFANTS SO DIFFICULT TO DIAGNOSE?

Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

the standardized urine-sugar test for reliable quantitative estimations

AMES **COLOR-CALIBRATED CLINITEST®**

BRAND Reagent Tablets

84060

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

- **full-color calibration, clear-cut color changes**
- **established "plus" system covers entire critical range**
- **standard blue-to-orange spectrum**
- **standardized, laboratory-controlled color scale**
- **"urine-sugar profile" graph for closer control**

IN ANXIETY—RELAXATION RATHER THAN DROWSINESS

STELAZINE®

brand of trifluoperazine

'Stelazine' has little if any soporific effect. "... patients who reported drowsiness as a side effect mentioned that they did not fall asleep when they lay down for a daytime nap. It is quite possible that, in some instances, 'drowsiness' was confused with unfamiliar feelings of relaxation."[1]

'Stelazine' is unique among tranquilizers because it relieves anxiety whether expressed as agitation and tension or as apathy, listlessness and emotional fatigue.

Available for use in everyday practice: Tablets, 1 mg., in bottles of 50 and 500; and 2 mg., in bottles of 50.

1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

SMITH KLINE & FRENCH

leaders in psychopharmaceutical research

